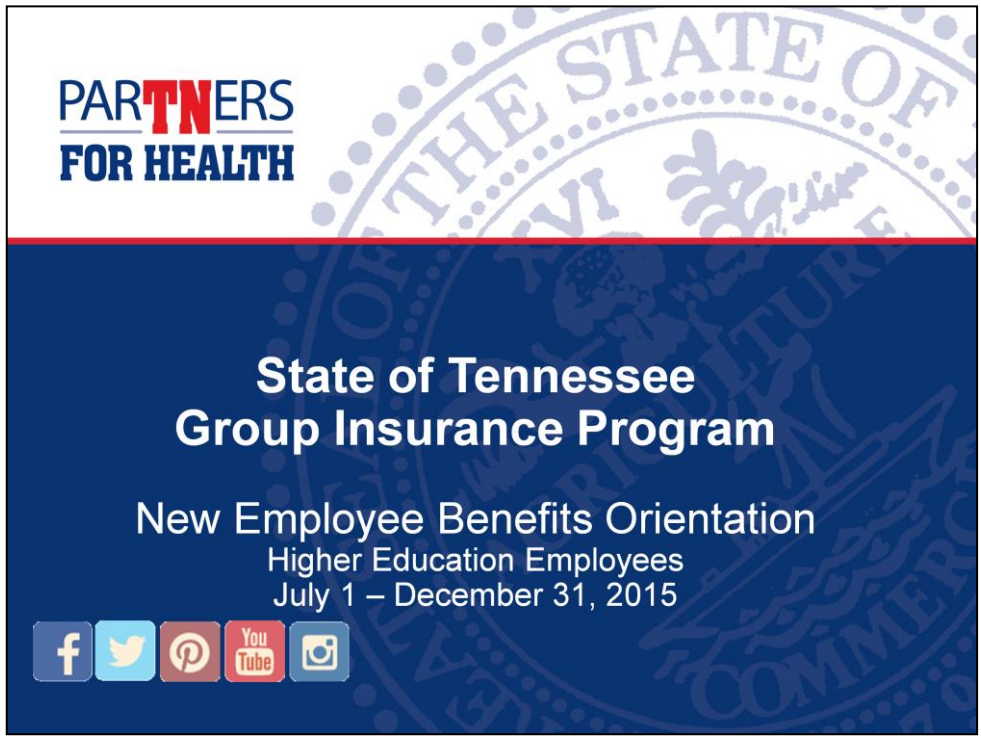
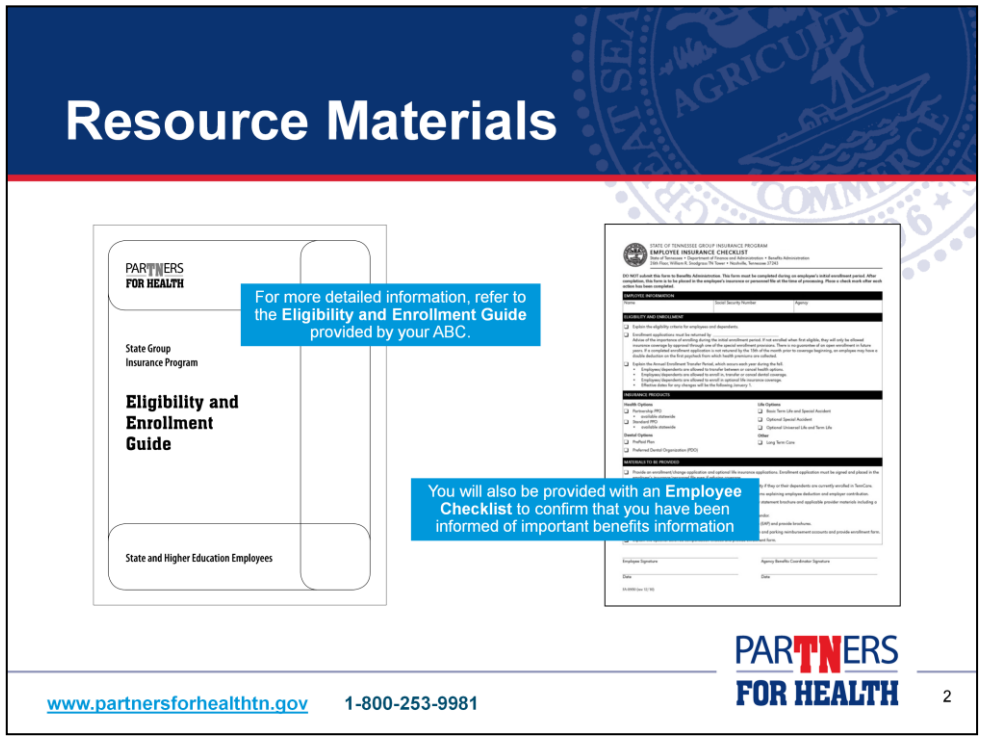


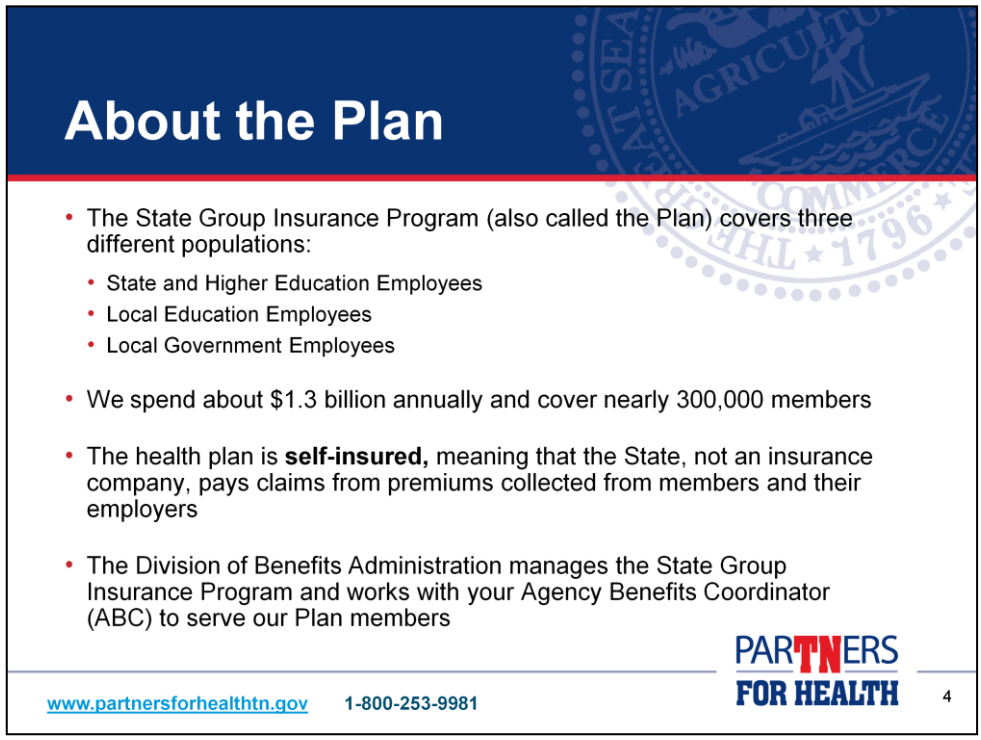
- Welcome to the State of Tennessee Group Insurance Program New Employee Benefits Orientation for Higher Education employees. This presentation will provide an overview of the benefits available to you as a new employee.

- The State provides a comprehensive benefits package for you and your eligible dependents including health, dental, vision, accident, life and long-term care insurance as well as other financial and counseling benefits. We will discuss all of these in detail later in the presentation.
- You have many options, and it's important that you understand your benefits and make informed decisions now since some of the benefits explained in this presentation are only available during the new hire period. Your Agency Benefits Coordinator will be able to tell you how long your new hire period lasts.
- We want to make sure that you fully understand your options. If you have questions after the presentation, please make sure to follow up with your Agency Benefits Coordinator.

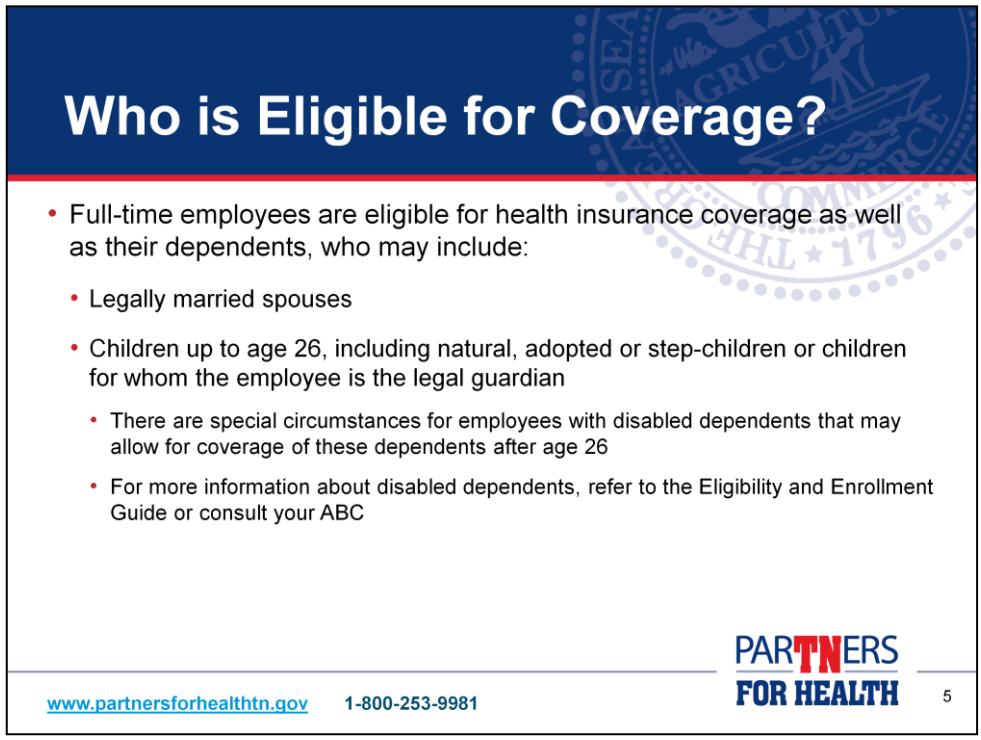


- This presentation is designed to offer you an overview of the benefits available to you as a new employee. More detailed information about the topics discussed during this presentation can be found in the Eligibility and Enrollment Guide. A copy of the Eligibility and Enrollment Guide can be found on the Benefits Administration website (**tn.gov/finance/ins**) under the "**Publications**" page.
- You will also be provided with an employee checklist to confirm that you have received this important benefit information. After the presentation, please sign the employee checklist and return it to your Agency Benefits Coordinator.
- These materials will be provided to you by your Agency Benefits Coordinator.

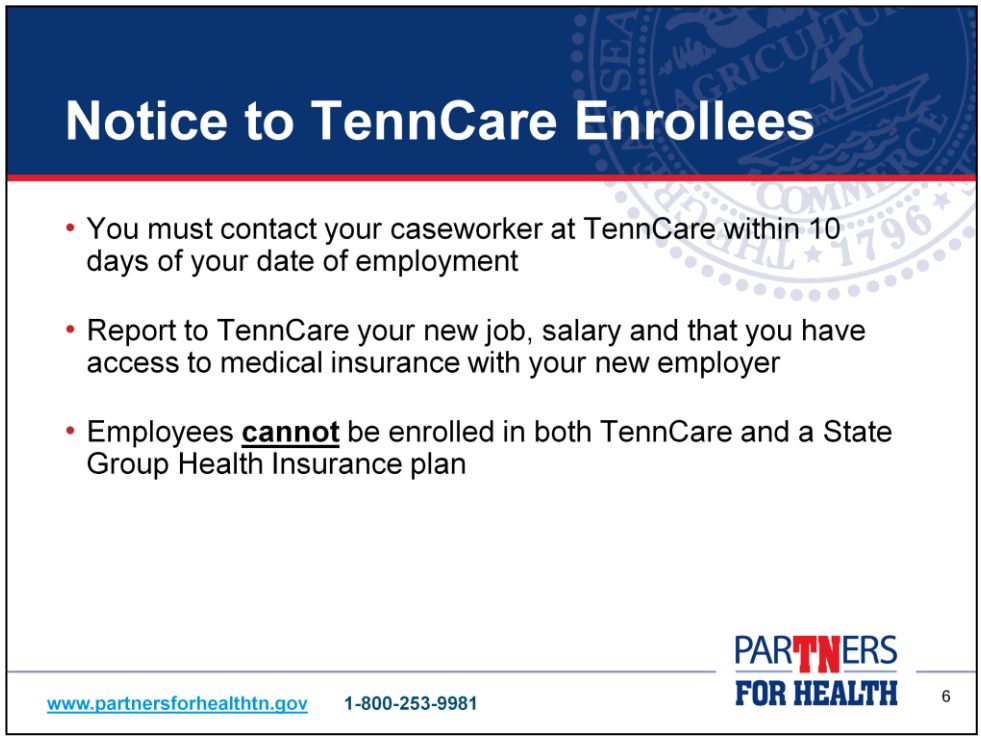
- As required by law, the State of Tennessee Group Health Program has created a Summary of Benefits and Coverage (SBC for short). It describes your health coverage options.
- The SBC is available from the main page of the Benefits Administration website at **www.tn.gov/finance/ins**. You may view and print a copy of the SBC at any time by visiting the website and clicking on the Summary of Benefits and Coverage button. You may also request a printed copy, free of charge, from your ABC.
- Much of the information found in the SBC is covered in more detail in other publications like the Eligibility and Enrollment Guide, Plan Document and Member Handbooks. These can be found under the "**Publications**" tab on the same website.



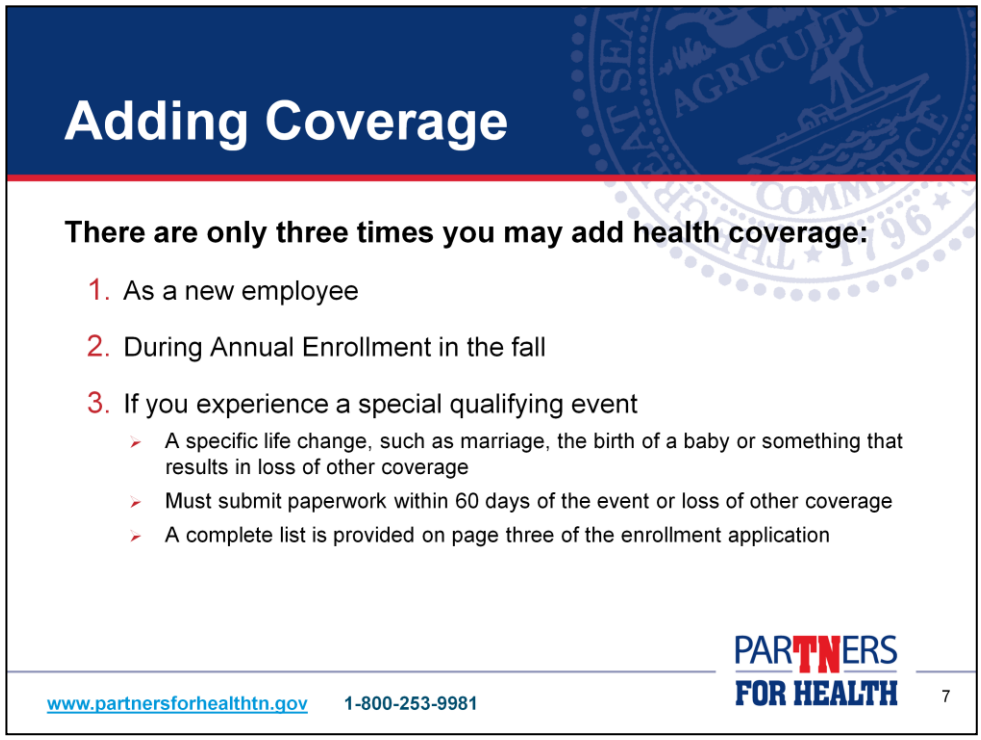
- The State of Tennessee Group Insurance program, also referred to as "the Plan," covers three different populations:
  - the State Plan which includes State and Higher Education employees
  - the Local Education Plan which covers K-12 teachers and support staff
  - the Local Government Plan which covers the employees of quasi-governmental agencies and municipalities
- In total, we spend about $1.3 billion annually in claims costs for our nearly 300,000 members.
- The Plan is self-insured, which means that all claims are paid by the State using the combined premiums paid by our members and any contributions that your employer makes toward your monthly premium. So, the State is the plan administrator rather than an insurance company. The State contracts with an insurance carrier to manage the Plan's provider networks, provide member services and manage claims payments on behalf of the State.
- The Division of Benefits Administration manages the State Group Insurance Program and works with Agency Benefits Coordinators, often called ABCs, to communicate program information to our members. Your ABC is the person who will help you with any benefits-related questions or concerns you may have.



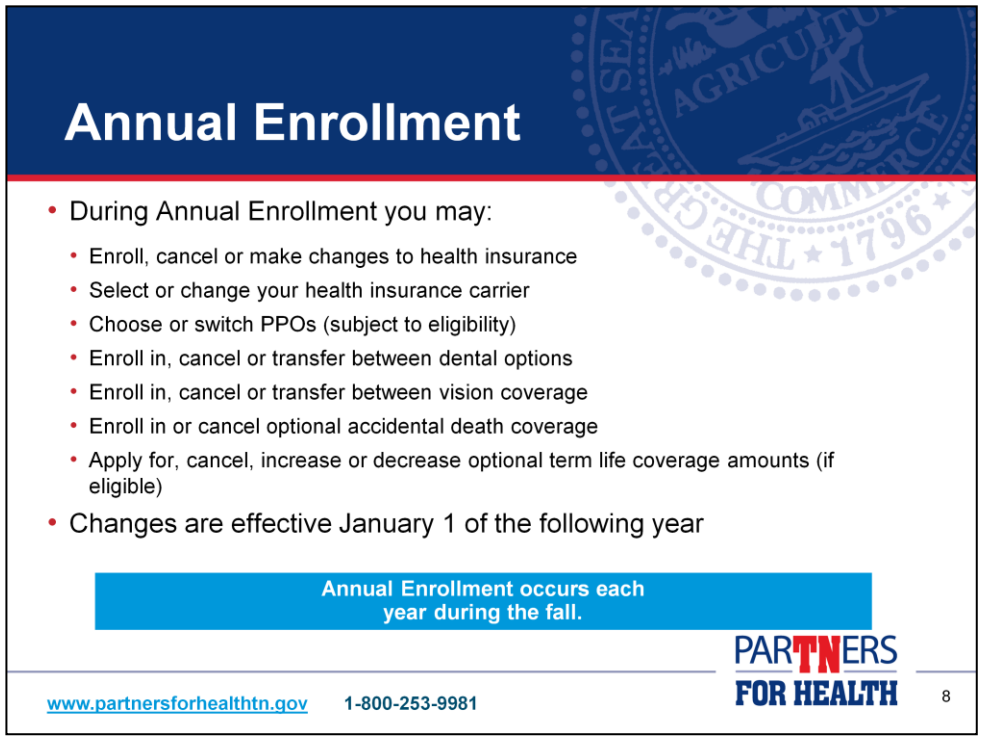
- Now that you know a little more about the Plan, let's discuss who is eligible for coverage. Generally speaking, full-time employees are eligible for benefits.
- If you are regularly scheduled to work no less than 30 hours per week in a non-seasonal, non-temporary position, you meet the insurance plan's definition of a full-time employee. Otherwise, you might still be defined as a full-time employee for health insurance purposes by federal law. Ask your Agency Benefits Coordinator for more details.
- If you have a family, you may choose to also cover your dependents. A dependent can be a legally married spouse or a child up to age 26. To be considered an eligible dependent, children must be natural, adopted or step-children or children for whom you are the legal guardian.
- If you have a disabled child, you may be able to continue coverage for your child after age 26. To learn more about special circumstances for disabled dependents, please refer to the Eligibility and Enrollment Guide or consult your ABC.



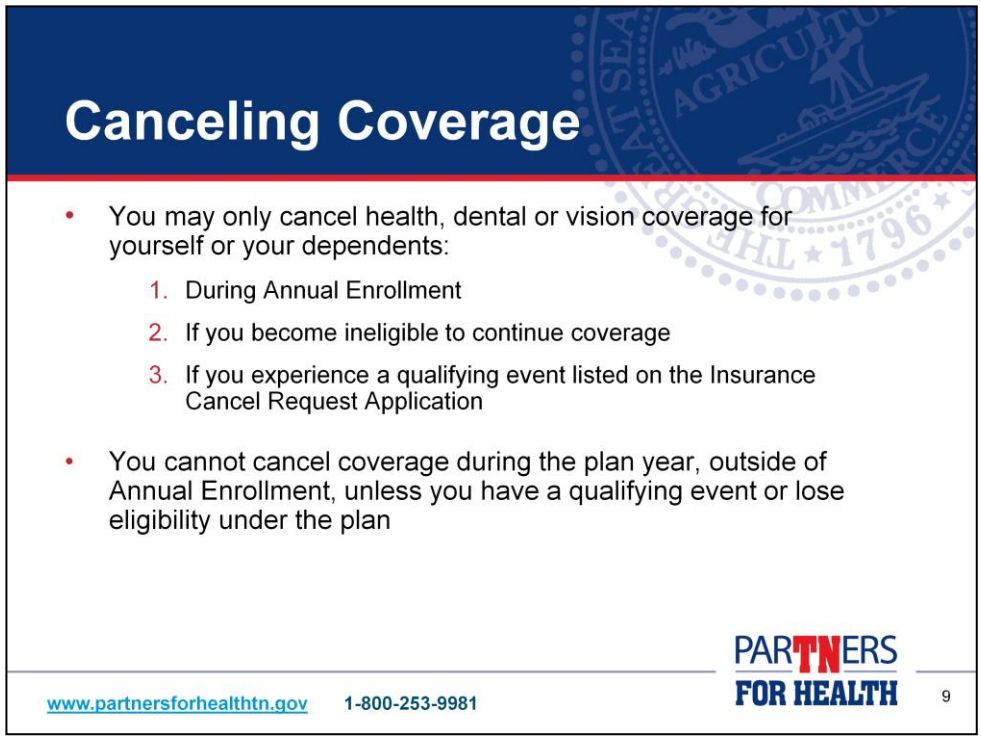
- If you are currently enrolled in TennCare, you must inform your caseworker at TennCare of your new employment within 10 days of your hire date. You will need to report to TennCare your new job, salary and that you have access to medical insurance with your new employer.
- Please note, you **cannot** be enrolled in both TennCare and a State Group Health Insurance plan.



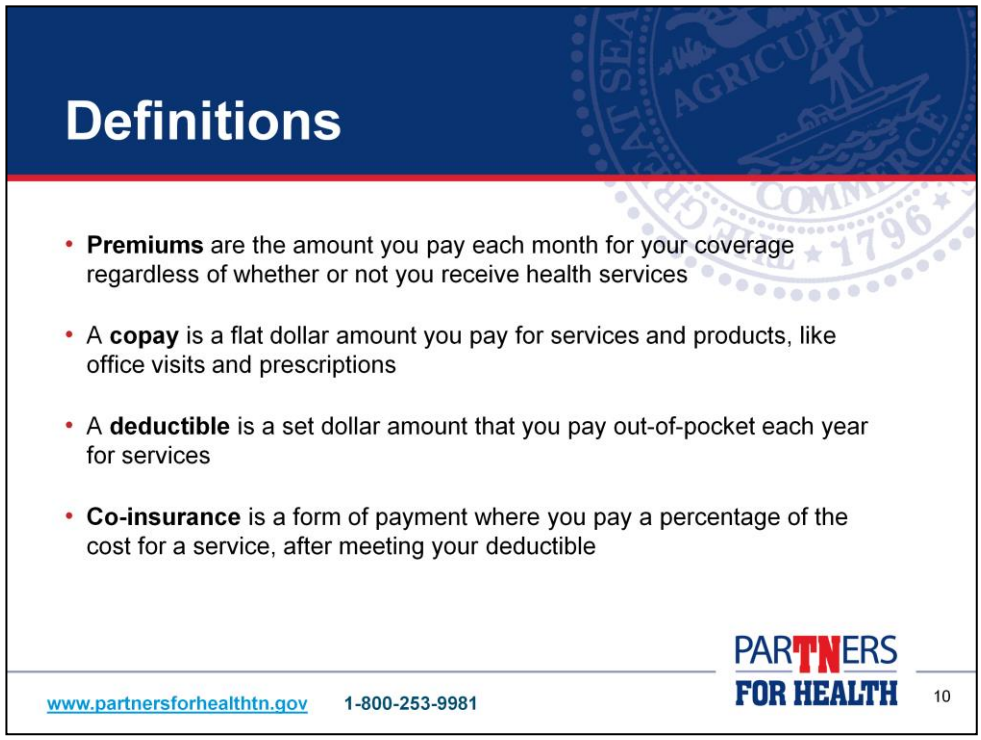
- There are only three times when you may add health coverage:
  - The first is right now, when you are a new employee
  - The second is during Annual Enrollment in the fall
  - And the third is if you experience a special qualifying event during the year
- A special qualifying event is a specific life change such as marriage, the birth of a baby or a spouse losing his or her health insurance coverage. If you do not select coverage now, but you later experience a special qualifying event, you must submit paperwork within 60 days of the event or loss of other coverage to add coverage. For a complete list of special qualifying events contact your ABC.



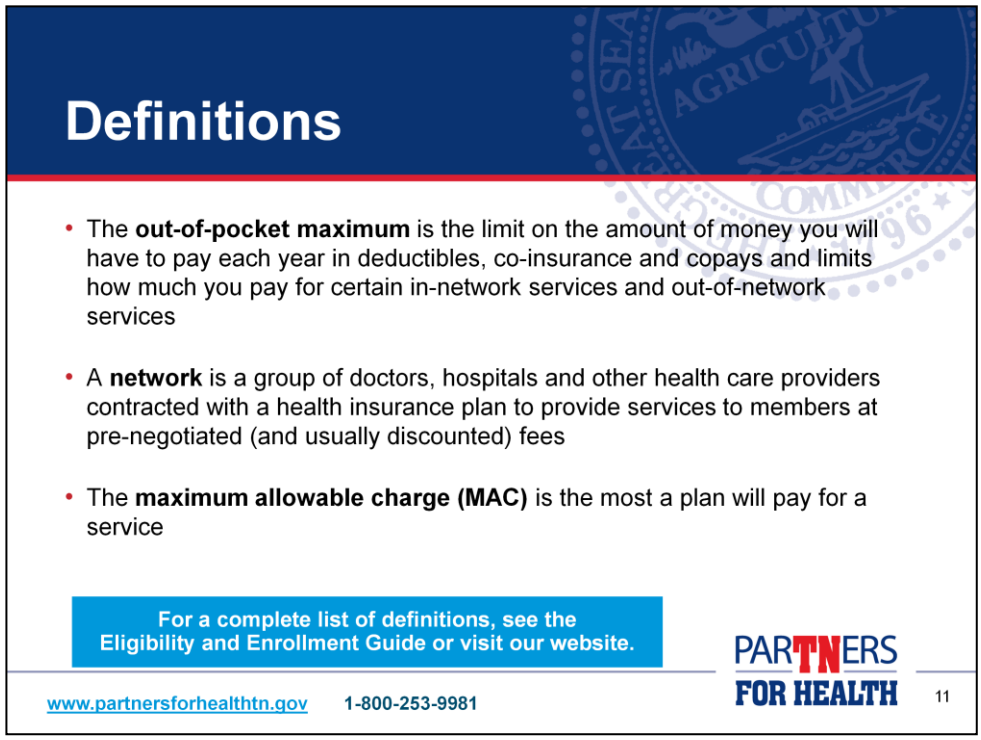
- An Annual Enrollment period is held each fall for most programs.
- First, members can choose health insurance options:
  - Enroll in or cancel health insurance for yourself or your eligible dependents
  - Choose either the Partnership or Standard PPO
  - You can select or change your health insurance carrier (BlueCross BlueShield or Cigna)
- You can also enroll in, cancel or transfer between dental options.
- Enroll in, cancel or transfer between vision coverage.
- You can also enroll in or cancel optional accidental death coverage.
- Also apply for, cancel, increase or decrease optional term life insurance if eligible.
- If you don't enroll in health insurance as a new employee, you will have the option to enroll during the fall Annual Enrollment.
- Changes made during Annual Enrollment will take effect January 1st of the following year.



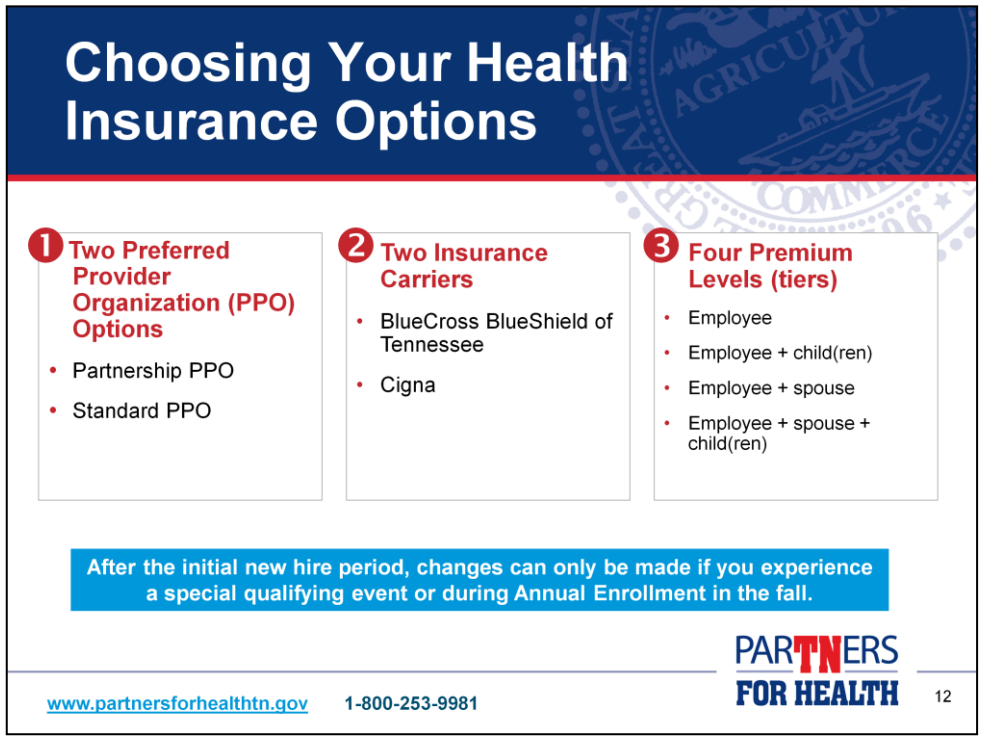
- If you decide to cancel your health, dental or vision coverage later, there are only three times when you may do so.
  - The first is during Annual Enrollment.
  - The second is if you become ineligible to continue coverage. For example, this could occur if you switch from full-time to part-time employment.
  - And, the third is if you experience one of the qualifying events listed on the Insurance Cancel Request Application.
- You can find a copy of this application by asking your ABC. Your ABC must sign the application before it's submitted.
- It's important to remember that, outside of Annual Enrollment, you cannot cancel coverage at any other time during the plan year unless you experience one of the approved qualifying events or you become ineligible to continue coverage.



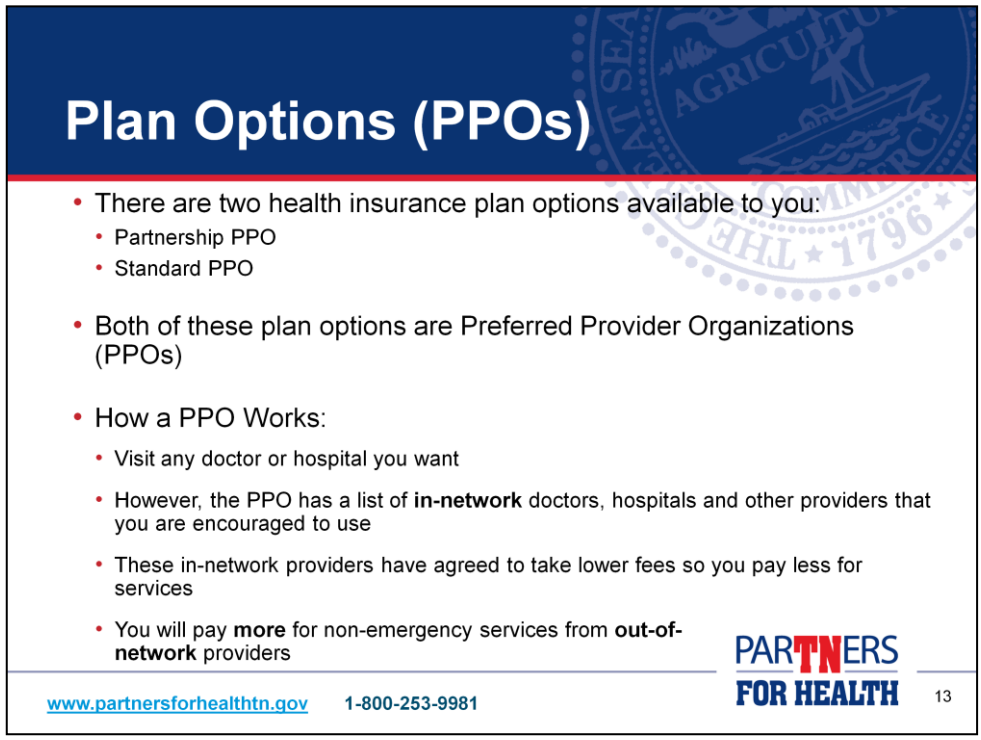
- Before we discuss the benefit options available to you, let's review some of the terms we use frequently to discuss health insurance and other benefits.
- It's important to know that you will be able to choose between two PPOs, or preferred provider organizations. Unlike most traditional PPOs, they are actually hybrid PPOs which include premiums, co-insurance, deductibles and copays.
- **Premiums** are the amount you pay each month for your coverage regardless of whether or not you receive health services that month. Your premium will be deducted from your paycheck automatically each month. Ask your ABC how your department handles monthly premiums to be sure.
- A **copay** is a flat dollar amount you pay for services and products, like office visits and prescriptions.
- A **deductible** is a set dollar amount that you pay out-of-pocket each year for services. It's important to note that there are separate deductibles for in-network and out-of-network services.
- **Co-insurance** is a form of payment where you pay a percentage of the cost for a service after meeting your deductible.



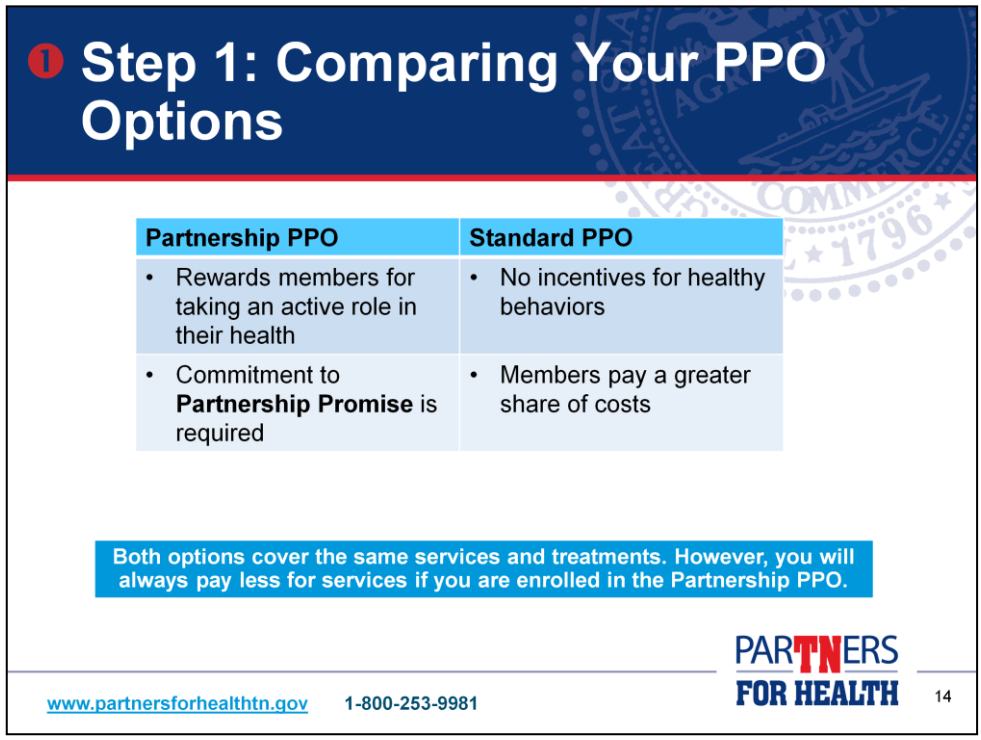
- The limit to the amount of money you are responsible for paying each year in deductibles, co-insurance and copays is called the **out-of-pocket maximum**. Once you reach your medical out-of-pocket maximum, the plan pays eligible expenses for the rest of the year and you won't have to pay any more out-of-pocket. This out-of-pocket maximum does not apply to premiums. There are also separate out-of-pocket maximums for in-network and out-of-network services. **Please note:** There is a separate pharmacy out-of-pocket maximum.
- During this presentation, you will hear references to in-network and out-of-network providers. A **network** is a group of doctors, hospitals and other health care providers contracted with a health insurance plan to provide services to plan members at pre-negotiated (and usually discounted) fees. Because the insurance company has not negotiated a lower price with out-of-network providers, you will pay higher amounts for services from these providers.
- All services have a **maximum allowable charge or MAC**. This is the most that a plan will pay for a service. If you see an out-of-network provider who charges more than the MAC for non-emergency services, you will pay the additional amount due. When you visit an in-network provider, you don't have to worry about exceeding the MAC. In-network providers agree in advance to fees that don't exceed the maximum.
- These are some of the most commonly used insurance terms. They should help you better understand our discussion of the benefits available to you as a new employee. To view a complete list of terms and definitions, see the Eligibility and Enrollment Guide or visit the ParTNers for Health website.



- Now that you have a better understanding of how insurance works, we will discuss the health insurance options available to you through the State Group Insurance Program. When making your health insurance selection, there are three things to consider:
  - the Plan option (PPOs)
  - the insurance carrier
  - the premium level (tiers)
- You will have options to choose from within each of these areas.
- The plan you choose depends on your specific needs.



- First, we will consider plan options. There are two plan options available to you: the Partnership and Standard PPOs. Both of these options are Preferred Provider Organizations, more commonly referred to as PPOs.
- With a PPO, you can visit any doctor or hospital you want. The PPO has a list of in-network doctors, hospitals and other providers that you are encouraged to use. Keep in mind, these in-network providers have agreed to take lower fees so you pay less for services. You will **ALWAYS** pay more for non-emergency services from out-of-network providers.



- Both the Partnership and Standard PPO offer in-network preventive care at no additional cost and offer access to the ParTNers for Health wellness program.
- No matter which PPO you choose, you'll have comprehensive and dependable coverage. Both options cover all of the same types of services and treatments. However, if you choose the Partnership PPO, you need to commit to taking an active role in your health by completing the Partnership Promise.

The State Group Insurance Program determines the Partnership Promise requirement and Healthways administers the Partnership Promise.

- If you enroll in the Partnership PPO versus the Standard PPO, you will save money on premiums and lower out-of-pocket expenses. In fact, on average an employee with no dependents can save $506 on premiums and out-of-pocket costs through the Partnership PPO versus the Standard PPO. An employee with a covered spouse and dependents can save $1,041 on average.
- The Partnership PPO has tools, resources and health coaches to help members get and stay healthy and support those with chronic conditions.
- By enrolling in the Partnership PPO you are agreeing to the terms of the Partnership Promise each year.
  - Both you and your covered spouse, if covered on your insurance, must fulfill the Partnership Promise even if the Partnership PPO is not your primary insurance plan.
  - The Partnership Promise is an annual commitment. In order to remain in the Partnership PPO, members and covered spouses have to meet the commitment each year by the assigned deadline. If you or your covered spouse fail to fulfill any requirement of the 2015 Partnership Promise, your entire household will be transferred to the Standard PPO in 2016.
  - The Partnership Promise requirements may change from one plan year to

the next.

- Children do not have to meet the requirements of the Partnership Promise.

Goal of the Partnership Promise: To help you get and stay healthy.

Why is this important? Poor health costs all of us:

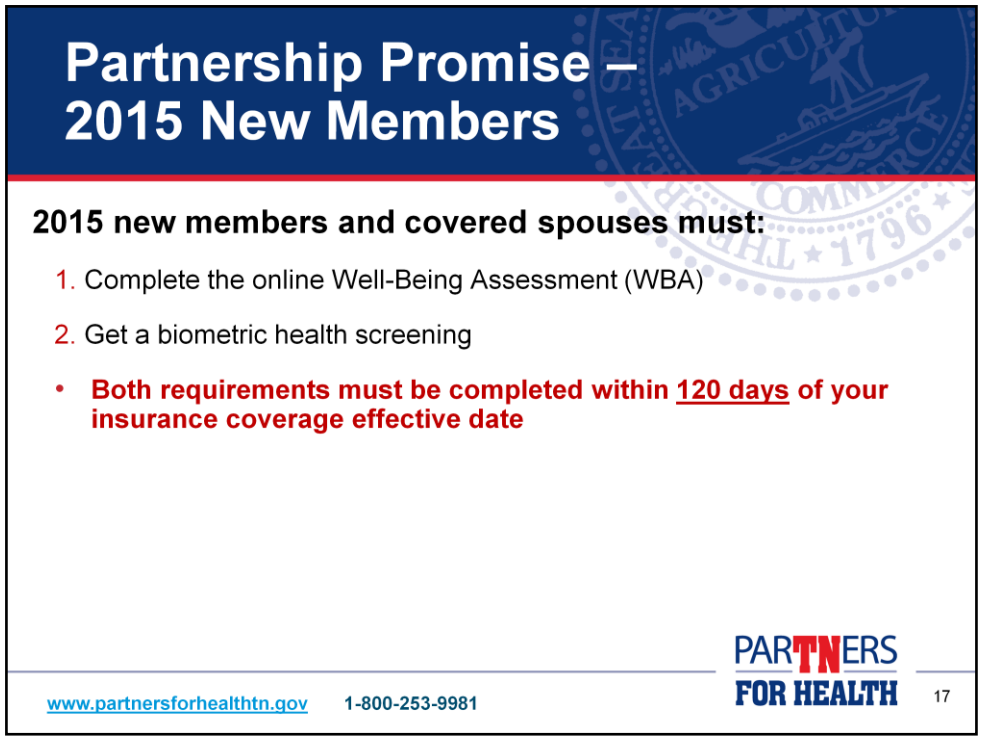
>We pay more in doctor's visits and hospitalizations

>All members pay higher health insurance premiums

>Impacts our quality of life from lifestyle choices we make each day

Now the good news: We can reduce healthcare costs with our own personal choices. Most members want to lose weight, eat healthy, increase exercise and quit tobacco. The Partnership PPO Wellness Program can help.

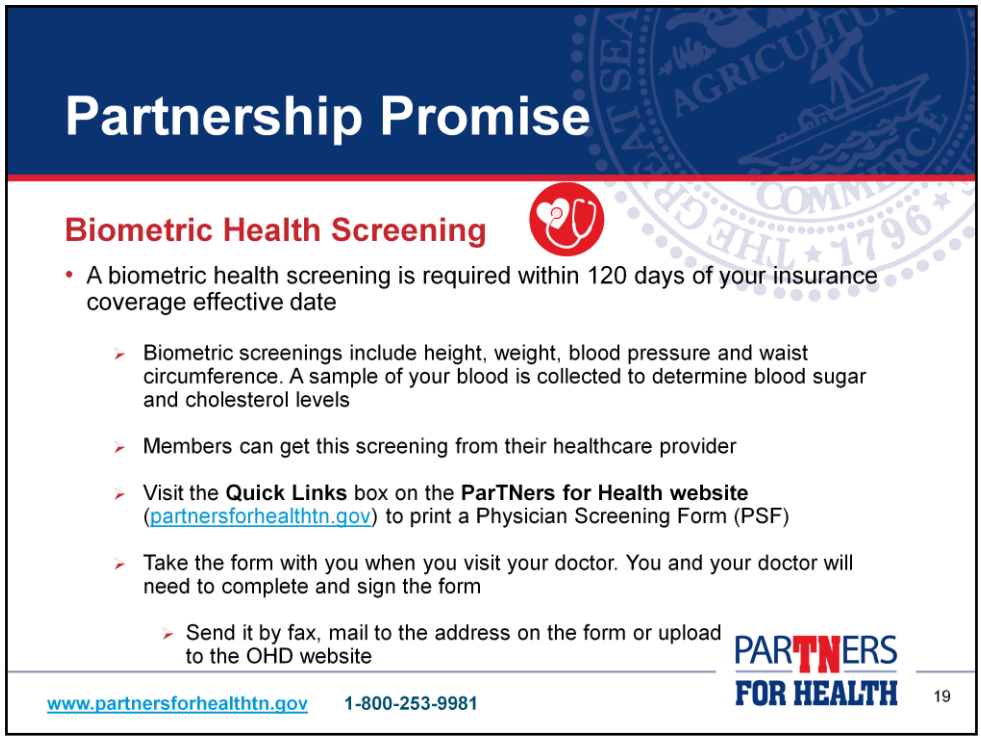
The Partnership PPO rewards members with lower costs because they have agreed to take steps to improve their health. These steps are called the Partnership Promise. **Partnership PPO members promise to take these steps in exchange for lower health insurance rates and lower costs for services.**



- 2015 new members and their covered spouses must:
  - Complete the online Well-Being Assessment.
  - Get a biometric health screening.
- **Both requirements must be completed within 120 days of your insurance coverage effective date.**
- If you choose the Partnership PPO, you must agree to the terms of the Partnership Promise each year. By enrolling in the Partnership PPO you are automatically agreeing to complete the Partnership Promise.
- **Note:** If an employee has a coverage effective date of September 1 – December 1, these new hires DO NOT have to complete the Partnership Promise requirements within 120 days.
- **The benefits of the Partnership Promise are open to all plan members. If you think you might be unable to fulfill the Partnership Promise, call our ParTNers for Health Wellness Program at 1-888-741-3390, and they will work with you and/or your physician, if you wish, to find an alternate way for you to meet the Promise.**
- We are now going to talk about the requirements in more detail.

- The online Well-Being Assessment (WBA) summarizes your overall health and offers steps you can take to improve.
  - By completing the private, online assessment, you will learn more about how your lifestyle habits affect your overall well-being.
- Go to www.partnersforhealthtn.gov, **click on "My Wellness Login" on the top left hand side of the home page** and create an online Well-Being Account to access the assessment.
- **You and your covered spouse, if he or she is on your health insurance, will have 120 days from your coverage effective date to complete the WBA.**
- If you do not have internet access, you can call Healthways at 1-888-741-3390 for an alternate way to complete the WBA.

NOTE: A person who knowingly provides false information in the WBA to maintain the Partnership PPO benefits may be moved to the Standard Plan. The State Insurance Plans have the right to recover the cost of benefits from any member who received these benefits through false information.

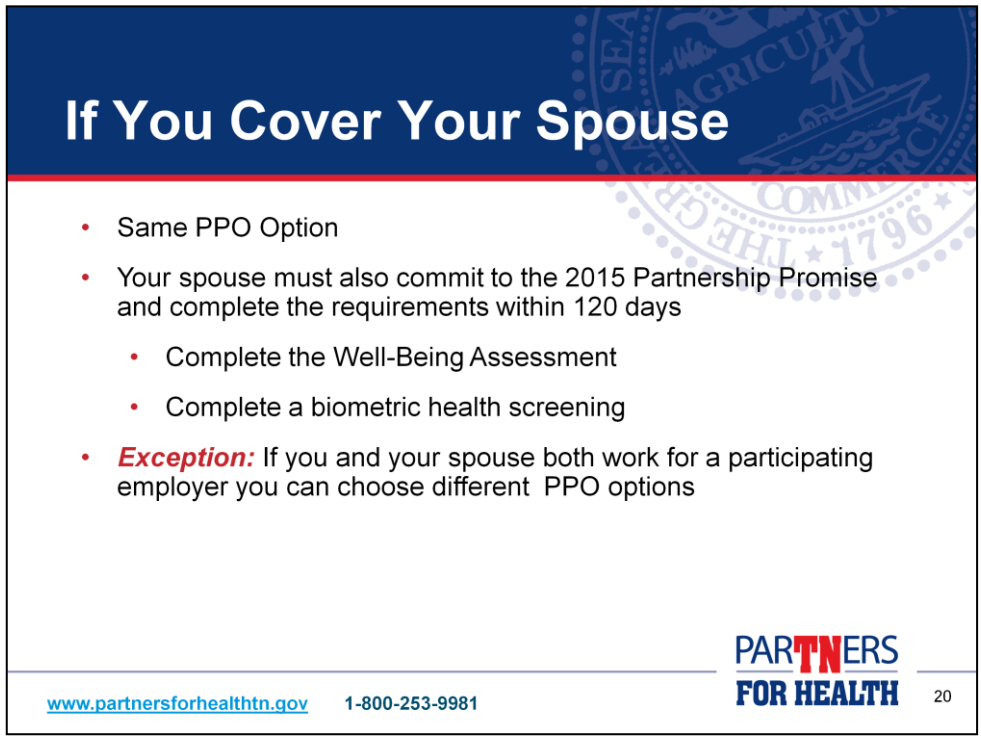


- New members and covered spouses who enroll in the Partnership PPO (EMPLOYEES AND COVERED SPOUSES) are required to get a biometric screening from your health care provider.
  - A biometric screening includes height, weight and waist circumference. A sample of your blood is also collected to determine blood sugar, cholesterol levels and other factors that can lead to lifestyle-related health complications. The biometric screening is not a part of the Well-Being assessment (WBA). This screening must be completed within 120 days once your new insurance coverage takes effect.
- You can complete your screening at a doctor's office.
- If you've been to the doctor recently, you may use screening results from a doctor's visit within the last 12 months.
- You can go to the Quick Links box on the ParTNers for Health homepage and click on "**Complete Your Biometric Screening**". This will take you directly to the OHD website to populate your Physician Screening Form.

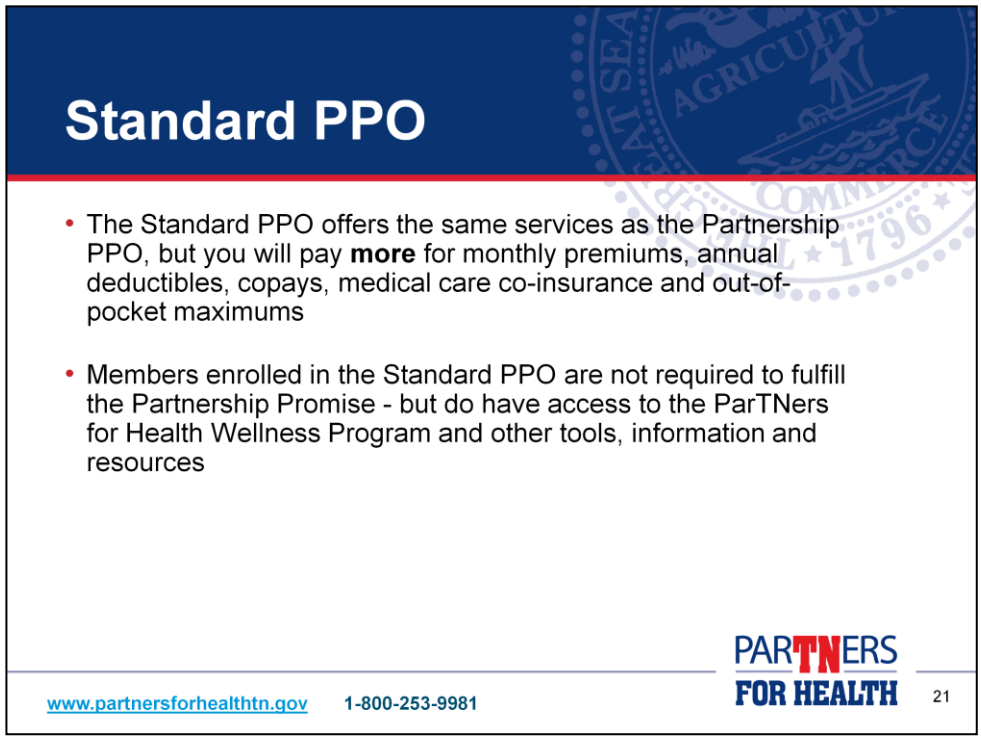
NOTE:

1. You must download and print your Physician Screening Form (PSF) from the OHD website; your PSF cannot be emailed.
2. Make sure you measure and write your waist circumference on your PSF.
3. The doctor will need to complete your form. If the form is not complete, your form will not be processed.
4. Both you and your physician must sign and date the form.
5. You or your doctor must fax (or mail) it to OHD within your 120 day deadline.
   - Fax the form to 214.203.0395
   - Mail to: Onsite Health Diagnostics, Attn: Results Dept., 7801 Mesquite Bend, Suite 106, Irving, Texas 75063.
   - You also have the option to upload your completed and signed PSF to the OHD website.
   - Instructions on how to upload the form can be found on the home page of the ParTNers for Health website .

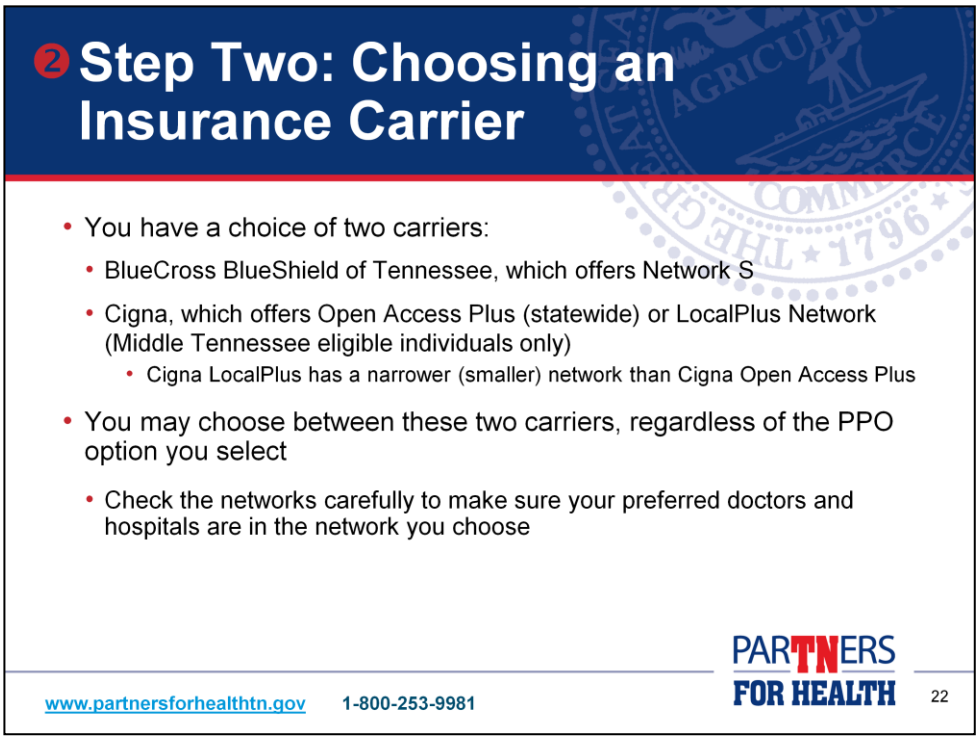
   If you do not have access to a computer, you can call Healthways at 1-888-741-3390, Monday to Friday, 8:00 a.m. to 8:00 p.m. CT and they will populate your PSF and mail it to you.



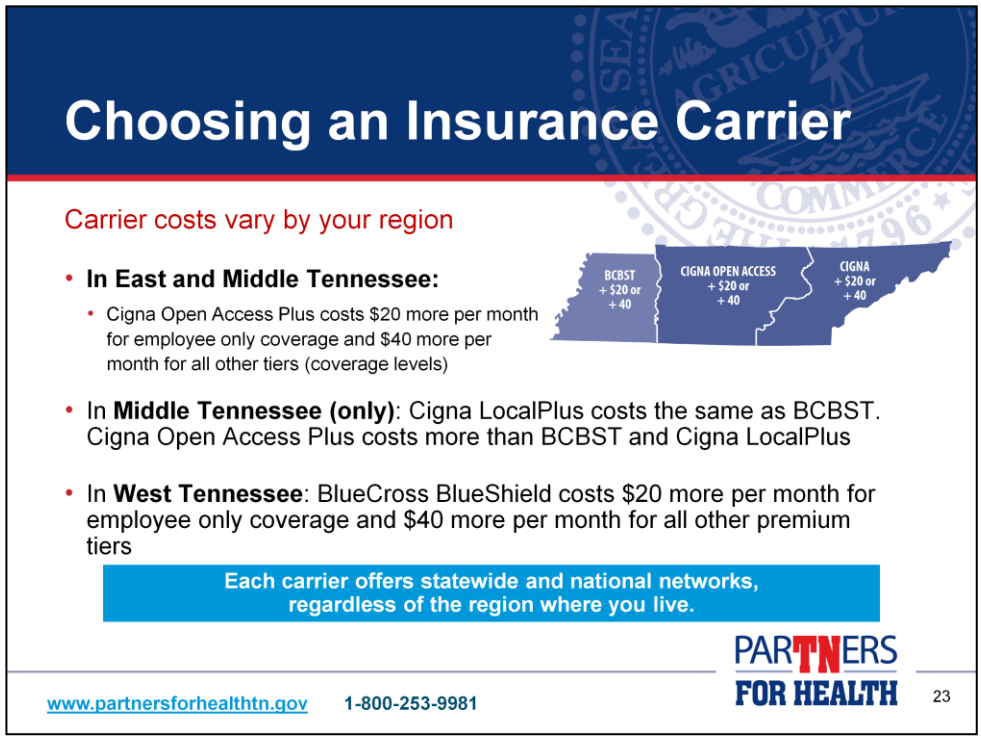
- You and your covered spouse must both choose the same PPO option. That means if you choose the Partnership PPO, you are both committing to complete the Partnership Promise within 120 days.
  - The requirements include:
    - Completing the online Well-Being Assessment
    - Completing a biometric health screening
- **The only exception** is if you both work for a plan that the State administers, you can choose different options if you each enroll in your own coverage. If you enroll in separate coverage, you can each choose your own health benefit option and insurance carrier, just like any two plan members who are not married.



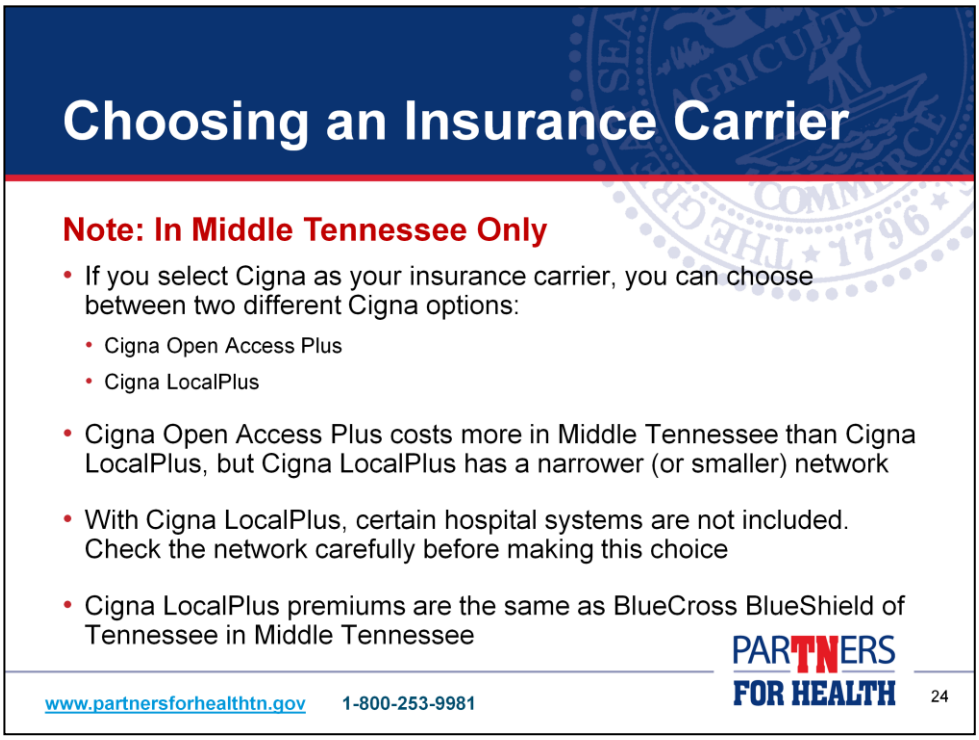
- The Standard PPO offers the exact same services as the Partnership PPO, but you will pay **more** for monthly premiums, annual deductibles, copays, medical care co-insurance and out-of-pocket maximums.
- Members enrolled in the Standard PPO are not required to fulfill the Partnership Promise, but do have access to the ParTNers for Health Wellness Program and other tools, information and resources at no additional cost.



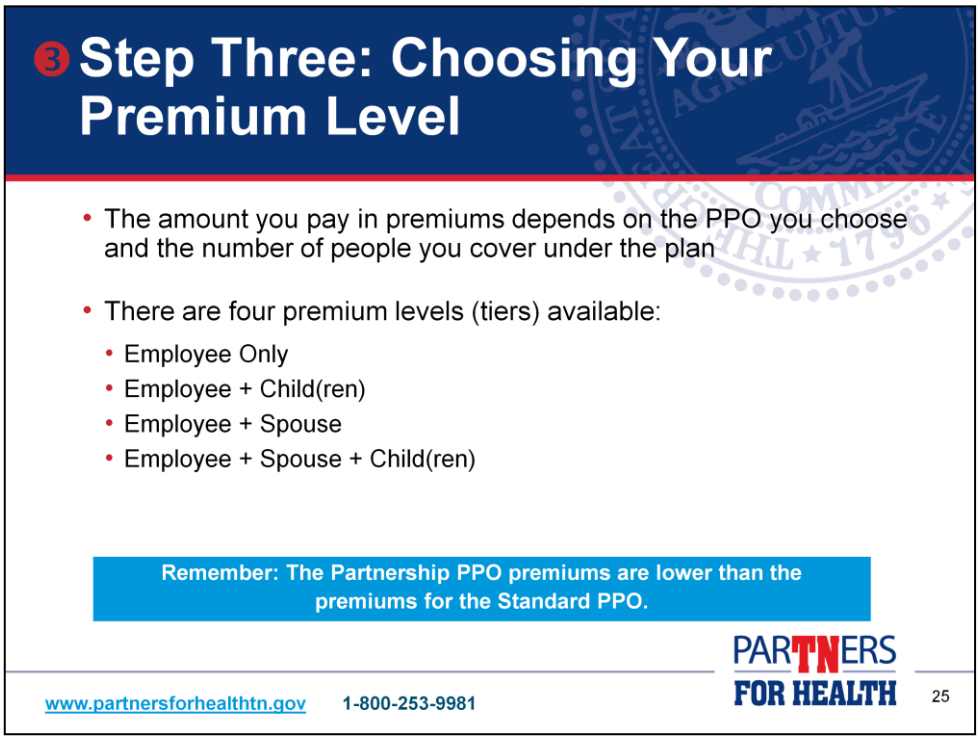
- The next step is to choose between two carriers - BlueCross BlueShield of Tennessee and Cigna.
  - BlueCross BlueShield of Tennessee, which offers Network S.
  - Cigna, which offers Open Access Plus (OAP) statewide or the LocalPlus Network only in Middle Tennessee.
- You may choose between these two carriers, regardless of the PPO option you select.
- Check the networks carefully for your preferred doctor or hospital when making your selection.
- Provider directories are available on the ParTNers for Health website (**partnersforhealthtn.gov**), by calling the carrier or from your ABC.
  - The online directories are found on the carrier's website and are always the most current version of the provider directories.
- Phone numbers for the carriers are listed on the inside cover of the Eligibility and Enrollment Guide.



- Depending on where you live, BlueCross BlueShield of Tennessee and Cigna have different premiums because the networks have different network surcharges in each region.
- You will want to choose your insurance carrier based on whether or not your doctor, hospital or facility participates in their network.
  - If you're in East or Middle Tennessee, Cigna Open Access Plus costs $20 more per month for employee only coverage and $40 more per month for all other tiers, and BlueCross BlueShield and Cigna LocalPlus (Middle TN members only) are less costly options.
  - If you are in Middle Tennessee, Cigna LocalPlus costs the same as BCBST, Cigna Open Access Plus costs more.
  - If you are a Cigna LocalPlus plan member, you must use the Cigna LocalPlus network to get the in-network level of benefits. **If you are traveling or out of state and a LocalPlus provider is not available, you can select a provider from Cigna Open Access Plus. If a provider is out-of-network, coverage will be paid at the out-of-network rate.**
  - If you're in West Tennessee, the BlueCross BlueShield of Tennessee plan costs $20 more per month for employee only coverage and $40 more per month for all other tiers. Cigna Open Access Plus is a less costly option.
- It's important to note that each carrier offers statewide and national networks, regardless of the region where you live.

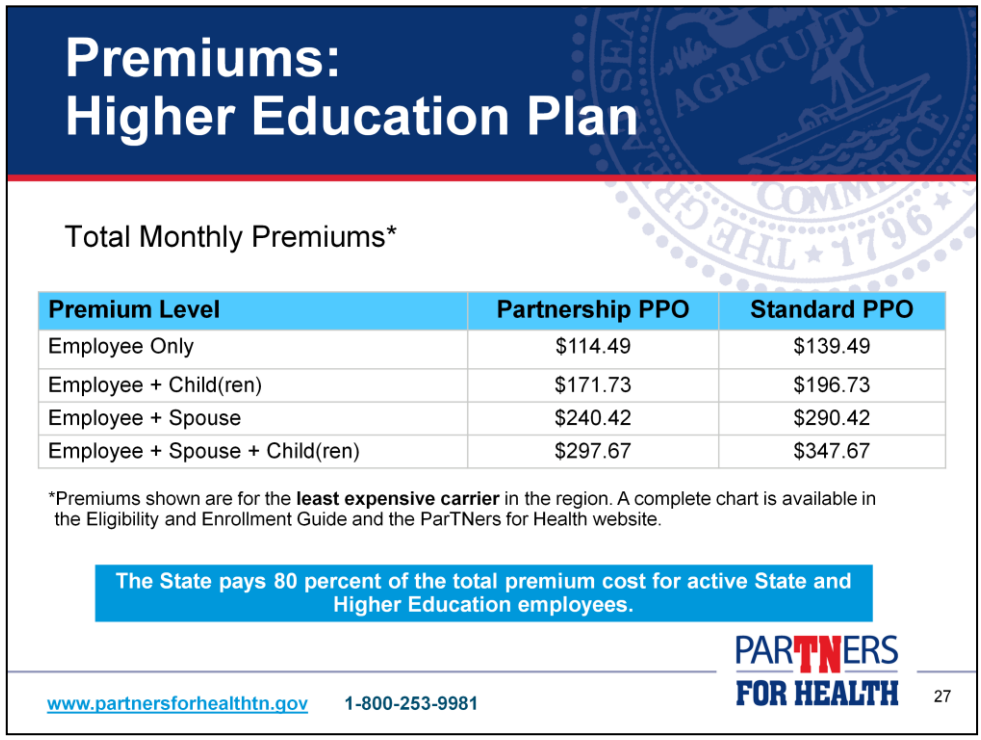


- **In Middle Tennessee Only:**
- If you select Cigna as your insurance carrier, you can choose between two different Cigna options, Cigna Open Access Plus or Cigna LocalPlus.
- Cigna Open Access Plus costs more in Middle Tennessee than Cigna LocalPlus, but Cigna LocalPlus has a narrower (or smaller) network.
  - For example, certain hospital systems are not included. St. Thomas hospitals (St. Thomas Midtown, West and Rutherford), among others are **NOT** included in the Cigna LocalPlus network.
- Check the network carefully before making this choice.
- Cigna LocalPlus premiums are the same as BlueCross BlueShield of Tennessee in Middle Tennessee.
- You can find more information and online provider directories on the **partnersforhealthtn.gov** website, under the "**Health Options**" tab, **Carrier Information**.



- Once you have selected your PPO option and carrier, you will need to choose your premium level. The amount you pay in premiums depends on the PPO you choose and the number of people you cover under the plan. There are four premium levels available: Employee Only, Employee + Child or Children, Employee + Spouse and Employee + Spouse + Child or Children.
- For most people, choosing a premium level is easy.
  - For instance, if you're single and don't have children, your premium level is employee only.
  - However, if you're married — either with or without children — you may also decide to select employee only. It depends on the needs of your family.
  - If, for instance, your spouse has health insurance with another employer, you could cover your children under the State Group Insurance Program or under your spouse's insurance. You will need to compare the programs and see which is better for you. Just remember, in most cases, if you're enrolling as a family, either under the second, third or fourth premium levels, all of you must be enrolled in the same health insurance option with the same insurance carrier.

- If you are married to an employee who works for the State, Higher Education or a participating Local Government or Local Education agency, you will have another option—you can each enroll in employee-only coverage. If you do that, you can each choose your own health benefit option and insurance carrier, just like any two plan members who are **not** married. If your family situation gives you options for your premium level, be sure to consider them carefully and choose the one that makes the most sense for you and your family.
- If you and your spouse are both State and Higher Education employees, you may each want to consider enrolling in employee only coverage or, if you have children, one of you may want to enroll in employee + child or children, to ensure that you receive the maximum life insurance benefit. However, an individual may only be covered under one policy.



- Here are the premiums for Higher Education Plan employees. For active employees, the State contributes 80 percent of the total premium cost and employees pay the balance.
- This chart shows the premiums for the **least expensive carrier** in each region. If you choose the more costly carrier for your region, add $20 for employee only coverage and $40 for **all other tiers**.
- A detailed premium chart is included in your Eligibility and Enrollment Guide and is also posted on the ParTNers for Health website.

- The Partnership and Standard PPO both cover the same services, treatments and products, such as:
  - In-network preventive care, x-ray, lab and diagnostics at no additional cost (**note**: there is a cost for advanced x-rays, scans and imaging)
  - Fixed copays for some services
  - Prescription drugs for a fixed copay
- Free preventive health services include, but are not limited to:
  - Flu vaccination and pneumococcal vaccinations
  - Annual preventive visit (i.e., physical exam)
  - Annual well-woman visit
  - Osteoporosis screening for women
  - Screenings for colon, breast or cervical cancer
- For some procedures, different medical criteria may apply based on the carrier you select.
- It's important to remember that you need to visit an in-network provider to receive preventive care services at no cost.
- Carriers also offer additional discounts for certain value-added benefits not covered by traditional insurance. This could include programs for weight loss, fitness club memberships or laser vision care. Refer to the BlueCross

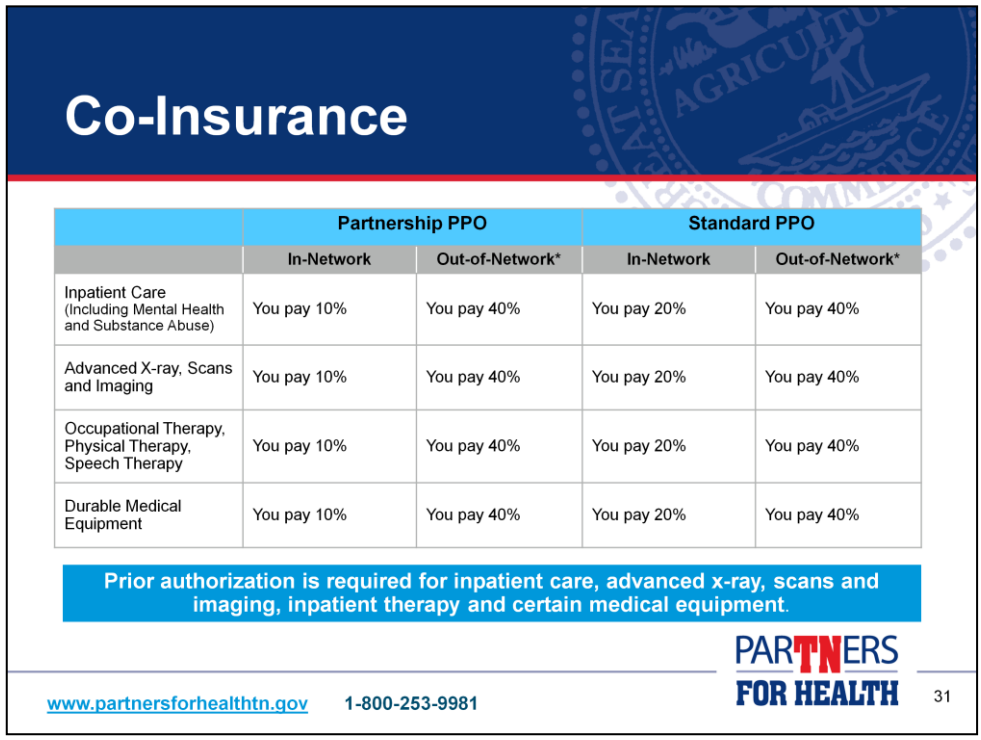
BlueShield and Cigna member handbooks or websites for more information.

Copays

	Partnership PPO		Standard PPO	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Preventive Care	No charge	$45 copay	No charge	$50 copay
Well-baby or Well-child Visits	No charge	$45 copay	No charge	$50 copay
Primary Care	$25 copay	$45 copay	$30 copay	$50 copay
Specialty Care	$45 copay	$70 copay	$50 copay	$75 copay
Prescription Drugs (30-day supply at Retail Pharmacy)	$5 copay generic $35 copay preferred brand $85 copay non-preferred brand	Copay for applicable tier **plus** amount over Maximum Allowable Charge (MAC)	$10 copay generic $45 copay preferred brand $95 copay non-preferred brand	Copay for applicable tier **plus** amount over Maximum Allowable Charge (MAC)

- This chart shows the copays associated with services covered under each PPO option. A copay is a flat dollar amount. For example, if you're enrolled in the Partnership PPO and you visit an in-network specialist, you will pay a $45 copay at the time of your visit. The allowed amount for the doctor's charge may be $100 for the service, but you only pay the copay and the plan pays the rest.
- As you can see, you will always pay less for copays in the Partnership PPO.

- You may have noticed on the previous chart that there is no charge for in-network preventive care. A good example is your annual physical. Regular preventive care is one of the most important things you can do to stay healthy, so we want to take a minute to highlight the free preventive care available to you as a member of the State Group Health Insurance Program.
- Members are entitled to an annual physical at no cost. That means you will not have a copay for your preventive care office visit, and your related routine lab work is always covered at 100 percent. In addition to your free annual physical, an annual well-woman check-up for you or your covered spouse is also covered free of charge. Just remember, to receive these benefits at no cost, you need to visit an in-network provider for all preventive care services. Copays and co-insurance may apply to out-of-network preventive care services.



- You will pay what's known as co-insurance for many services, including hospital stays and covered outpatient care.
- Co-insurance is a percentage of the total cost for a service. Your share of the cost depends on the total charge and whether you receive services in-network or out-of-network. Before the plan begins paying its share of co-insurance, you need to meet an annual deductible, which we will talk about in a minute.
- The chart you see here shows a sample of the co-insurance amounts under the Partnership and Standard PPOs. You will notice two important things. First, you pay less if you use an in-network provider. Second, you pay less if you enroll in the Partnership PPO.

Annual Deductibles

	Partnership PPO		Standard PPO	
Annual Deductible	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Employee only	$450	$800	$800	$1,500
Employee + Child(ren)	$700	$1,250	$1,250	$2,350
Employee + Spouse	$900	$1,600	$1,600	$3,000
Employee + Spouse + Child(ren)	$1,150	$2,050	$2,050	$3,850

You pay the annual deductible before co-insurance benefits kick in. But, any costs you pay toward your deductible will apply to your out-of-pocket maximum.

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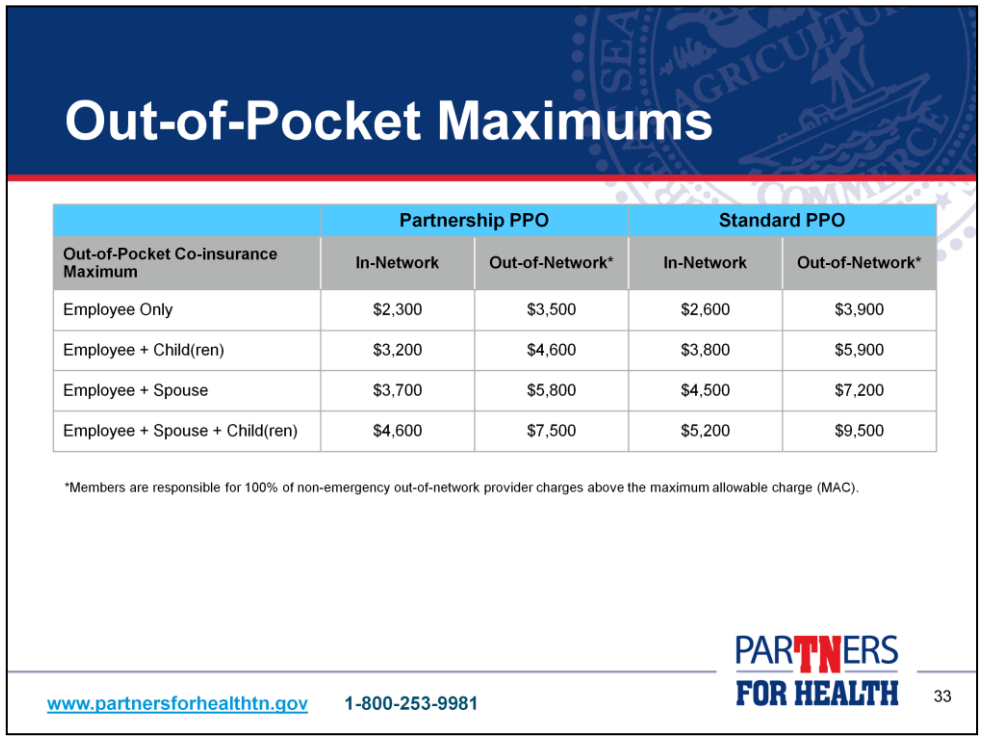
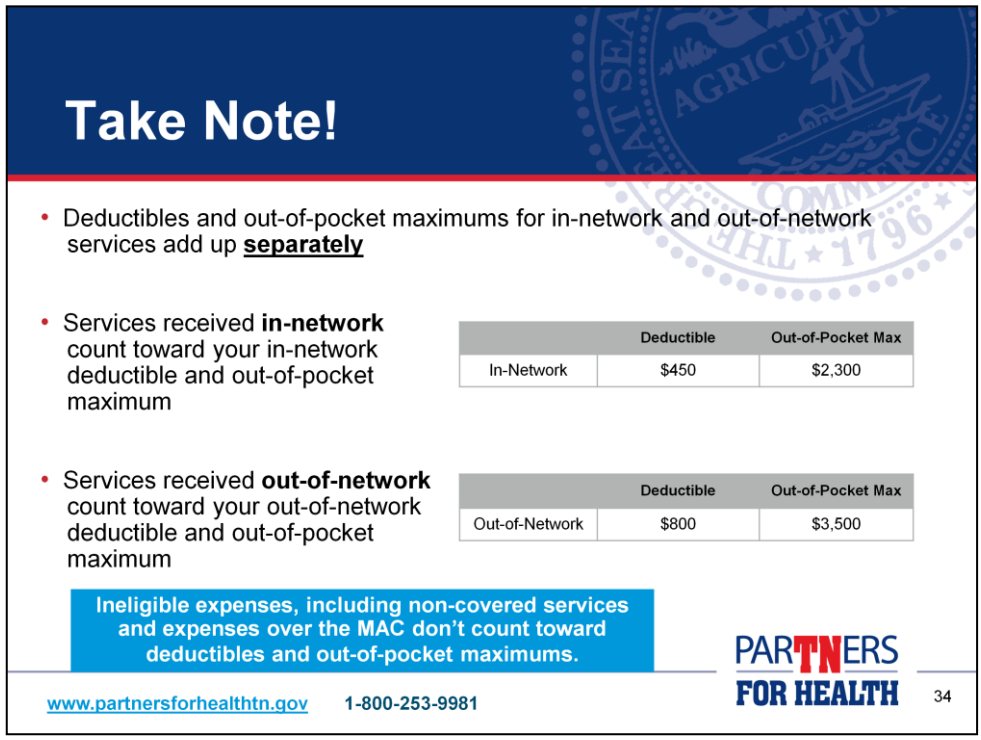
- As we mentioned earlier, the annual deductible is the amount you must pay each year before your PPO pays any hospital or other charges that are covered through co-insurance. As you can see in this chart, your annual deductible will be lower under the Partnership PPO. It will also be lower for in-network services. A lower deductible means that for charges that require co-insurance, the Partnership PPO starts paying a portion of the cost sooner than the Standard PPO.
- It's important to keep in mind that the deductible does not apply to primary care visits, prescription drugs or other services or products that require only a copay. Only eligible expenses will apply toward the deductible. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.
- You should also know that no single family member will be subject to a deductible greater than the employee only amount.



- Finally, as a particularly important benefit, PPOs have out-of-pocket maximums. You can see that the maximums are lower under the Partnership PPO. They are also lower for in-network services.
- These maximums provide financial protection for you by limiting how much you would have to pay in any given year if you or a covered family member had a serious illness or injury.
- If your out-of-pocket spending reaches the medical out-of-pocket maximum for in-network services, you will not have to pay any costs for additional covered in-network medical services for the rest of the year. Remember for the Partnership and Standard PPO there is a separate pharmacy out-of-pocket maximum. And, just like your annual deductible, no single family member will be subject to an out-of-pocket maximum greater than the employee only amount.
- As you can see, these maximums provide you and your covered dependents with peace of mind and financial protection against a catastrophic illness or injury.



- It's important to understand that deductibles and out-of-pocket maximums for in-network and out-of-network services add up separately. For the purpose of this example, we are looking at costs for someone with single coverage in the Partnership PPO.
- If you incur in-network expenses, that amount goes toward the in-network deductible of $450 and out-of-pocket maximum of $2,300. If you incur out-of-network expenses, that amount goes toward the out-of-network deductible of $800 and out-of-pocket maximum of $3,500. Also, eligible pharmacy expenses apply separately toward the pharmacy out-of-pocket maximum.
- Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted. Remember, when you visit an in-network provider, you don't have to worry about exceeding the MAC. In-network providers agree in advance to fees that don't exceed the maximum.
- Copays do not count toward your deductible but do apply to out-of-pocket maximums, except for in-network pharmacy in the Partnership and Standard PPOs which have a separate out-of-pocket maximum.

- You may have noticed that prescription drug coverage was included in the list of covered services we discussed earlier. Your health plan also includes pharmacy benefits. You do not have to make a choice about your pharmacy benefits. These are automatically included when you choose either the Partnership or Standard PPO.
- Pharmacy benefits are administered by CVS/caremark, one of the largest pharmacy benefits managers in the country. Their network of more than 1,600 pharmacies in Tennessee includes many major chains and independent pharmacies.
- The State's prescription drug plans require a copay but how much you pay depends on the prescription tier. Deductibles do not apply to pharmacy benefits for prescription drugs in the Partnership and Standard PPO. Your copay depends on whether you use a 30-day retail pharmacy or a 90-day network pharmacy (either through mail order or a 90-day retail pharmacy) and which PPO you choose. Your copay also depends on whether your prescription is filled with generic, preferred brand or non-preferred brand medication. They are also referred to as "tiers."
  - **Lowest cost**: Tier one/generic drug. A generic drug is a Food and Drug Administration (FDA) – approved equivalent of a brand-name drug. It is equal to the brand-name product in safety, effectiveness, quality and performance. You pay the least when you fill a prescription with a generic drug.

- **Higher cost**: Tier two/preferred drug. A preferred brand is a brand-name drug that is included on the drug list. Your cost will be higher for a preferred brand than for a generic, but less than for a non-preferred brand.
- **Highest cost**: Tier three/non-preferred brand A non-preferred brand is a brand-name drug that is not on the drug list. You will pay the most if you prescription is filled with a non-preferred brand.

- The in-network pharmacy out-of-pocket maximum for a person in the Partnership PPO with employee only coverage is $2,500. The in-network pharmacy out-of-pocket maximum for someone with any of the three forms/types of family coverage is $5,000. After a member reaches this amount in drug copays, he/she will pay $0 in drug copayments for the rest of the year for in-network coverage.
- CVS/caremark has more than 67,000 independent pharmacies throughout the U.S. About 916 pharmacies in Tennessee will fill 90-day prescriptions in the Retail 90 Network.
- Tobacco Cessation: The State's prescription drug coverage provides free tobacco quit aids to members who want to stop using tobacco products.
- You can refer to the Eligibility and Enrollment Guide or the ParTNers for Health website for more information about pharmacy benefits.

Prescription Drug Copays

	Partnership PPO		Standard PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
30-Day Supply (only from pharmacies in the 30-day network)	$5 copay generic $35 copay preferred brand $85 copay non-preferred brand	Copay, plus any amount exceeding MAC	$10 copay for generic $45 copay for preferred brand $95 copay for non-preferred brand	Copay, plus any amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$10 copay generic $65 copay preferred brand $165 copay non-preferred brand	Copay, plus any amount exceeding MAC	$20 copay for generic $85 copay for preferred brand $185 copay for non-preferred brand	Copay, plus any amount exceeding MAC
90-Day Supply (certain maintenance medications from 90-day pharmacy or mail order)	$5 copay generic $30 copay preferred brand $160 copay non-preferred brand	Copay, plus any amount exceeding MAC	$10 copay generic $40 copay preferred brand $180 copay non-preferred brand	Copay, plus any amount exceeding MAC

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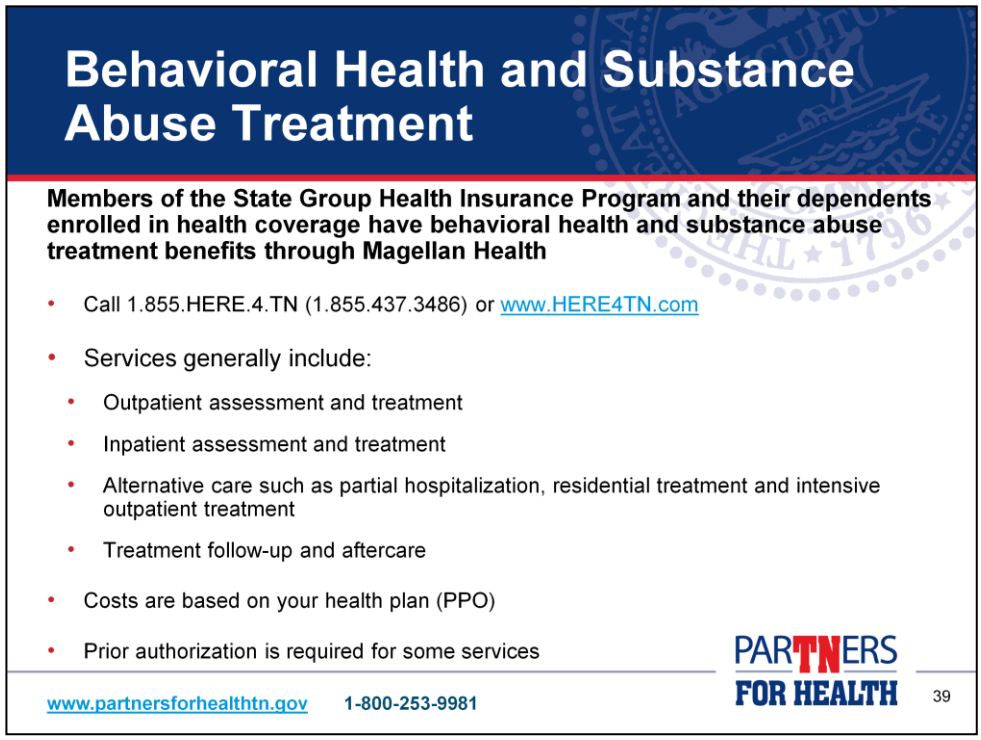
www.partnersforhealthtn.gov 1-800-253-9981

- This chart shows the copays for prescription drug coverage under the Partnership and the Standard PPOs. Again, the coverage is the same for each PPO, but the copays will be less expensive in the Partnership PPO.
- You will also save money by using the 90-day network to receive your medications through mail order or at a participating “mail at retail” pharmacy. **Please note**: Specialty medications have a 30-day supply limit and must be filled at a CVS/caremark specialty network pharmacy.
- You can see from the chart that copays are lower for certain maintenance medications, when you use the mail order benefit or a 90-day network retail pharmacy. These specific maintenance medications include statins, antihypertensives and oral diabetic medications, insulins and supplies. Please note that diabetic supplies include needles, test trips and lancets only.

- Both Behavioral Health Benefits and the Employee Assistance Program, or EAP, are included for everyone with medical benefits in all plans – you do not have to sign up to receive this benefit.
- Employee Assistance is offered to Higher Education employees if you are benefits eligible. You do not have to be enrolled in medical to receive this benefit.
- You and your dependents receive EAP benefits.
- We'll go into more detail about EAP and Behavioral Health Benefits in the following slides.

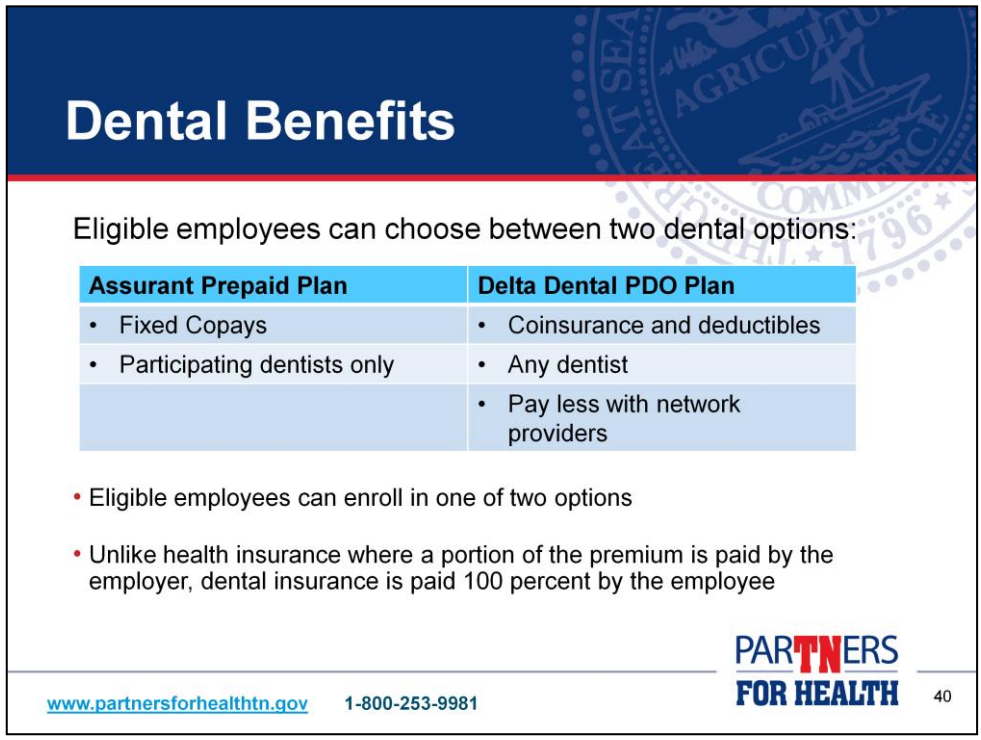
- **Employee Assistance Program (EAP):**
  - The Employee Assistance Program (EAP) helps you and your family with both workplace and personal issues. Services are free, confidential and available to members 24/7. You and your eligible dependents may get up to five, free counseling sessions per problem episode, per year.
  - Your EAP also offers work-life services, financial and legal services, assistance finding eldercare and dependent care services and much more.
- **Work/Life Resources for all employees include:**
  - Work-Life Services can help you and your family members find solutions to the challenges you may face throughout all life stages. These issues can include prenatal care, adoption, infant and child care, education resources, retirement planning, senior care and special needs services, among others.
- **Legal/Financial Consultations for all employees include:**
  - You can talk with an attorney to discuss your legal concerns. You may choose to have a phone or in-person consultation with a local attorney. Either way, the initial session is free to you. Visits or calls are completed within 60 minutes. After hour services are available for emergencies.
  - You can be connected with a financial expert for a telephone consultation through your program. You may speak with someone right away, or a financial counselor will call you back within three hours. Phone consultations are free to you and are completed in 60 minutes. Additional sessions are offered at a discounted rate after your first free hour.
- **Additional Tools for managers and supervisors:**

- Onsite EAP trainings are available if you have 15 or more participants. Please contact Deborah Roberts, 1.800.450.7281, ext. 74641 or daroberts@magellanhealth.com. Go to www.here4tn.com for a list of trainings – more than 70 seminars are currently offered!
- Workplace support consultants are available 24/7 for management consultations and critical incident support services. Just call (1.855.HERE4TN) and ask to speak with a Workplace Support Consultant.



- Members and their dependents enrolled in health coverage have behavioral health and substance abuse treatment benefits through Magellan Health.
  - Call 1.855.HERE4TN (1.855.437.3486) to access services or www.HERE4TN.com to access services:
    - Outpatient assessment and treatment
    - Inpatient assessment and treatment
    - Alternative care such as partial hospitalization, residential treatment and intensive outpatient treatment
    - Treatment follow-up and aftercare
- To receive maximum benefit coverage, participants must use a network provider and in some instances such as inpatient care, obtain preauthorization.
  - Magellan Health can be reached toll-free at 1.855.HERE.4.TN (1.855.437.3486) any time, day or night, to speak with a trained professional for a referral.
  - Participants may see an out-of-network mental health provider without calling for a referral; however, coinsurance and copayments will be higher. Participants are also subject to balance billing by the out-of-network provider, meaning that they will pay the difference between the maximum allowable charge and the actual charge. In addition, participants are at risk of having inpatient benefits totally denied.

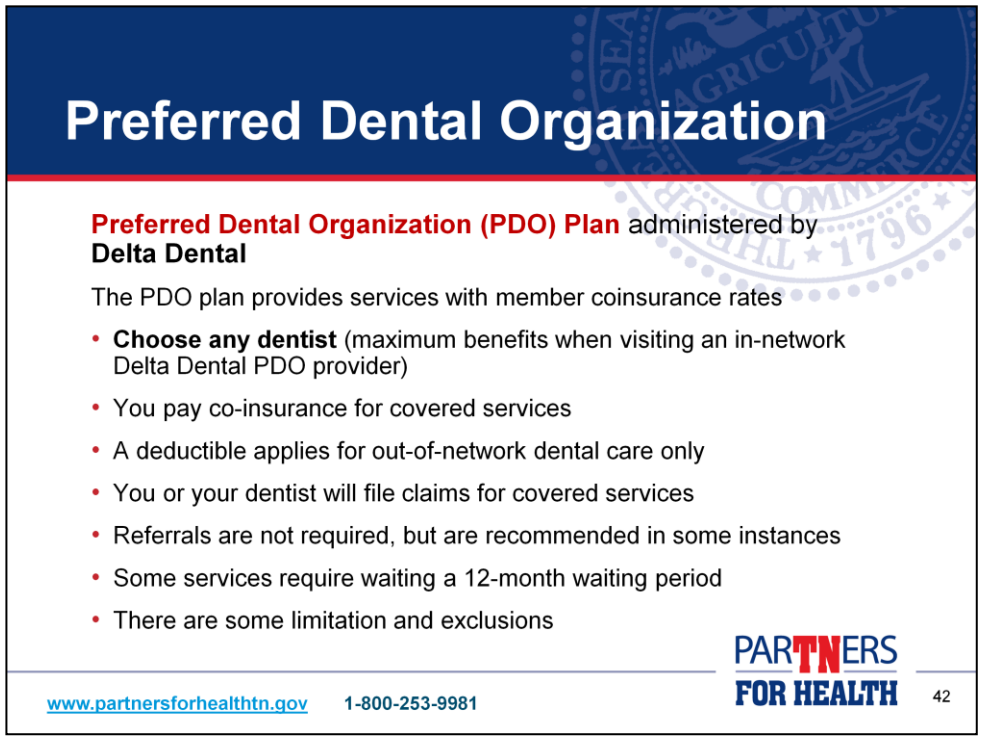
- Copays and co-insurances for these services are based on your PPO selection, and prior authorization is required for some out patient and all inpatient services. Contact Magellan Health using the contact information on the inside cover of the Eligibility and Enrollment Guide to access this benefit.



- Now let's talk about dental benefits.
- You do not have to be enrolled in health coverage to enroll in dental insurance.
- You can choose between two dental plans – a Prepaid Plan and a Preferred Dental Organization often called a PDO.
- In the prepaid plan, you must select from a specific group of dentists. Under the PDO plan, you may visit the dentist of your choice; however, members receive maximum savings when visiting a PDO network provider. Both dental options have specific guidelines for benefits such as exams and major procedures, and have a four-tier premium structure just like health insurance. As with health coverage, be sure to check with the dental provider to make sure the dentist you want is in the network.
- You can enroll in dental coverage as a new employee or during Annual Enrollment. You may also enroll if you experience a special qualifying event.
- Like health insurance, you pay premiums upfront for dental coverage regardless of whether or not you use any services. What you pay depends on the plan you choose. However, unlike health insurance where a portion of the premium is paid by the employer, the cost of dental insurance is paid 100 percent by the employee.
- You cannot terminate your enrollment in the dental plan during the year,

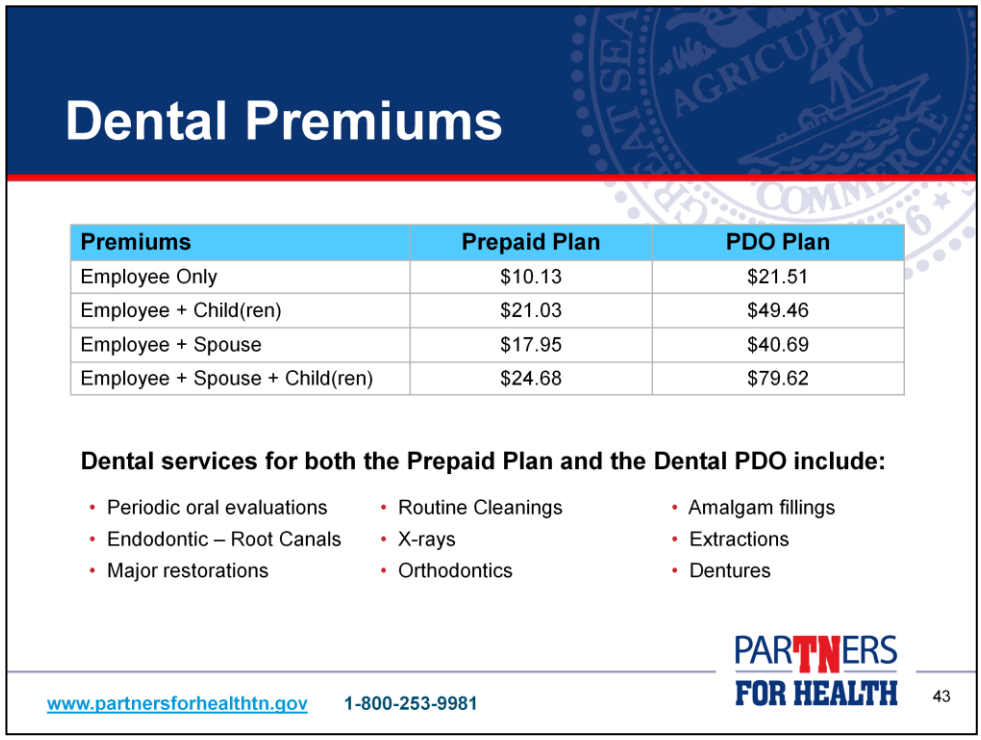
except during the Annual Enrollment period for the following year.

- The **Prepaid Plan** is administered by Assurant Employee Benefits and provides services at predetermined copay amounts from a limited network of participating dentists and specialists.
- **To receive benefits**, you must select a dentist from the Prepaid Plan list and notify Assurant of your selection. You can search for participating dentists at Assurant Employee Benefits – select the **DentiCare Network**. Complete a dentist selection form and return it to Assurant. The form is located on the back of the prepaid dental handbook which is available on our website or you can get a copy from your Agency Benefits Coordinator.
- There are some areas in the state where the network dentists are not available. Be sure to carefully review the provider directory. Some dental offices may be closed to new enrollment.
- You must use your selected dentist to receive benefits.
- This plan provides services at predetermined member copay amounts (reduced fees) for dental treatments.
- There are no deductibles to meet, no claims to file, no waiting periods for covered services, no annual dollar maximum and pre-existing conditions are covered.
- Referrals are not required.
- To find a dentist in Assurant's network, visit the dental section of the ParTNers for Health website or call the Assurant call center at the number listed on the inside cover of the Eligibility and Enrollment Guide.

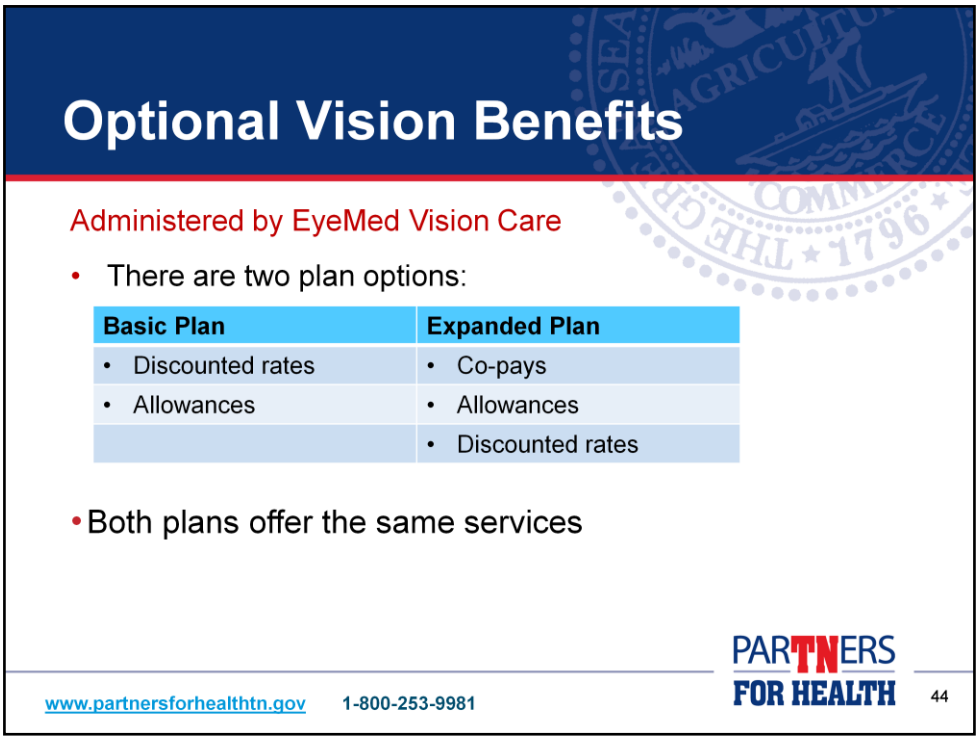


The PDO plan is administered by **Delta Dental**. It provides services with member coinsurance rates.

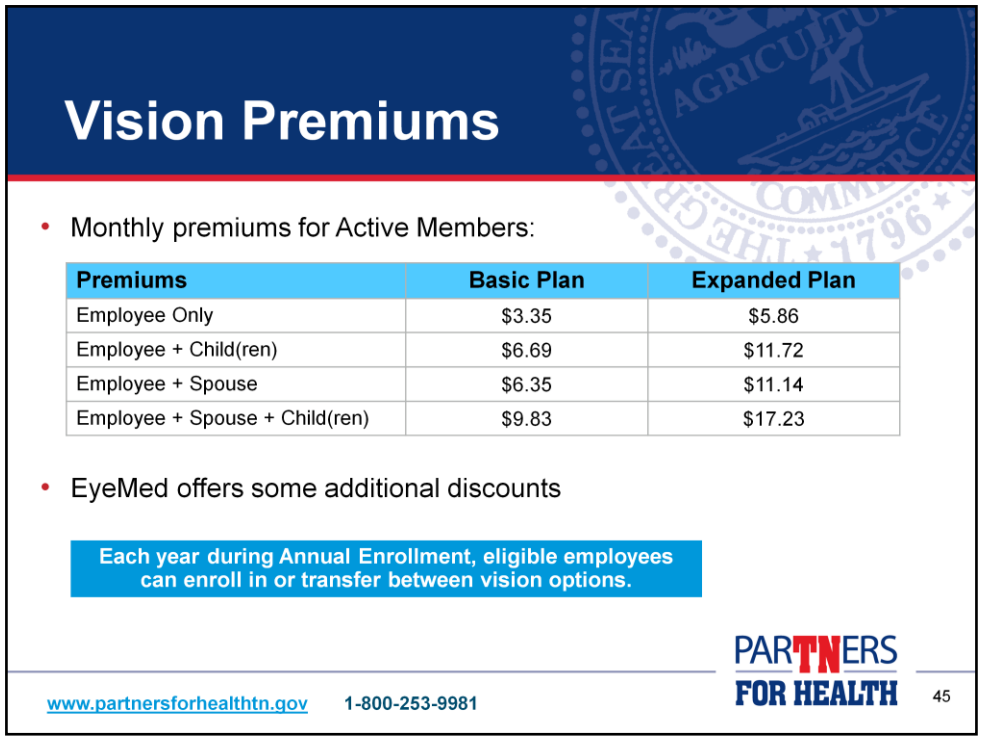
- You can choose any dentist (maximum benefits when visiting an in-network Delta Dental PDO Provider).
- You pay co-insurance for covered services.
- A deductible applies for out-of-network dental care only.
- You or your dentist will file claims for covered services.
- Referrals are not required, but are recommended in some instances.
- Some services such as crowns, dentures, orthodontics; require a 12-month waiting period before benefits begin.
- There are limitations and exclusions, for example, there is no benefit for replacement of a tooth missing before effective date of coverage.
- You can find a dentist in Delta Dental's network by visiting the dental section of the ParTNers for Health website or by calling the customer service center at the number listed on the inside cover of the Eligibility and Enrollment Guide.



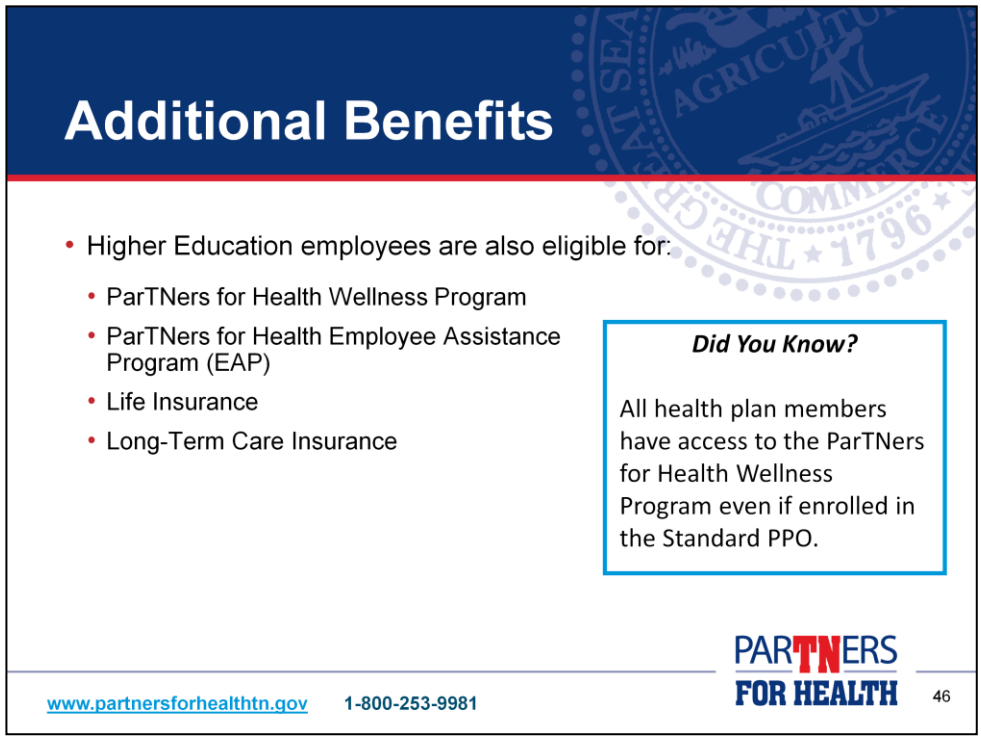
- This chart shows the premiums associated with each dental plan. Just like health insurance, there are four premium levels from which you can choose. The premium level you select will depend on the number of dependents you choose to cover.
- Dental services for both Assurant Prepaid Plan and the Delta Dental PDO include:
  - Periodic oral evaluations
  - Routine Cleanings
  - Amalgam fillings
  - Endodontics – Root Canal
  - X-rays
  - Extractions
  - Major restorations
  - Orthodontics
  - Dentures
- You can see a comparison chart of the services offered under each plan in your Eligibility and Enrollment Guide or by visiting the dental section of the ParTNers for Health website.



- The optional vision plan is administered by EyeMed Vision Care.
- Vision coverage is available to all Higher Education employees and dependents.
- **Choose from two plans:**
  - With the basic plan, you pay a discounted rate or the plan pays a fixed-dollar allowance for services and materials.
  - The expanded plan provides services with a combination of copays, allowances and discounted rates.
- Both plans offer the same services including:
  - Annual routine eye exam (once every calendar year)
  - Frames (once every two calendar years)
  - Eyeglass lenses (once every calendar year)
  - Contact lenses (once every calendar year)
  - Discount on Lasik/Refractive surgery
- In-network and out-of-network benefits are available. See **partnersforhealthtn.gov** for a list of limitation and exclusions.
- You will receive the maximum benefit when visiting a provider in EyeMed's Select Network.



- This chart shows the premiums associated with each vision plan. There are four premium levels from which you can choose, and the premium level you select will depend on the number of dependents you choose to cover.
- Members are responsible for the full premium.
- **EyeMed offers some additional discounts**:
  - 40 percent off on additional pairs of eyeglasses at any network location, after the vision benefit has been used.
  - 15 percent off conventional contact lenses after the benefit has been used.
  - 20 percent off non-covered items such as lens cleaner, accessories and non-prescription sunglasses.
  - **Expanded plan only**: 25 percent to 50 percent savings on premium progressive lenses and anti-reflective lenses.
- If you do not enroll in the vision plan as a new employee, you can add coverage later during Annual Enrollment. Each fall during Annual Enrollment, eligible employees can enroll in or transfer between vision options.



- In addition to health, dental and vision benefits, you also have access to other benefits – some you will receive automatically when you enroll in health insurance, while others are optional benefits in which you must choose to enroll. These additional benefits include the ParTNers for Health Wellness Program, the ParTNers for Health Employee Assistance Program (EAP), life insurance and long-term care insurance. We'll talk more about these in the following slides.

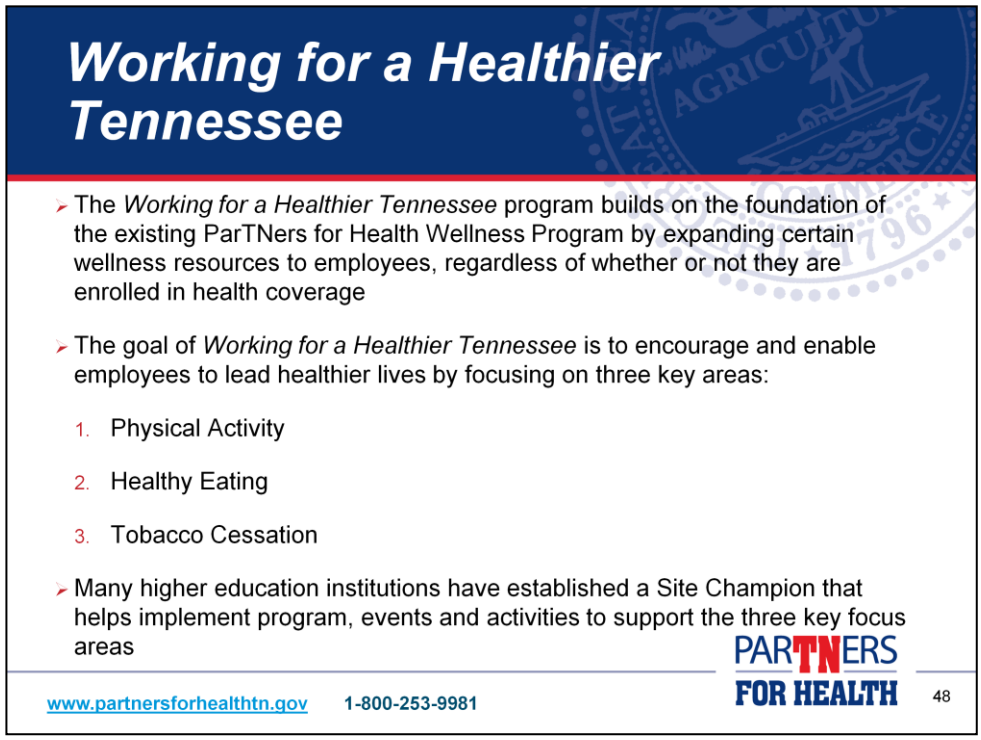
ParTNers for Health Wellness Program

Health plan members don't have to be in the Partnership PPO to take advantage of the tools, information and support you need to take charge of your health and feel your best. The ParTNers for Health Wellness Program is **FREE** to all health insurance plan members, eligible spouses and dependents. Everybody can take small steps to improve their health. Even small steps can add up to make a big difference.

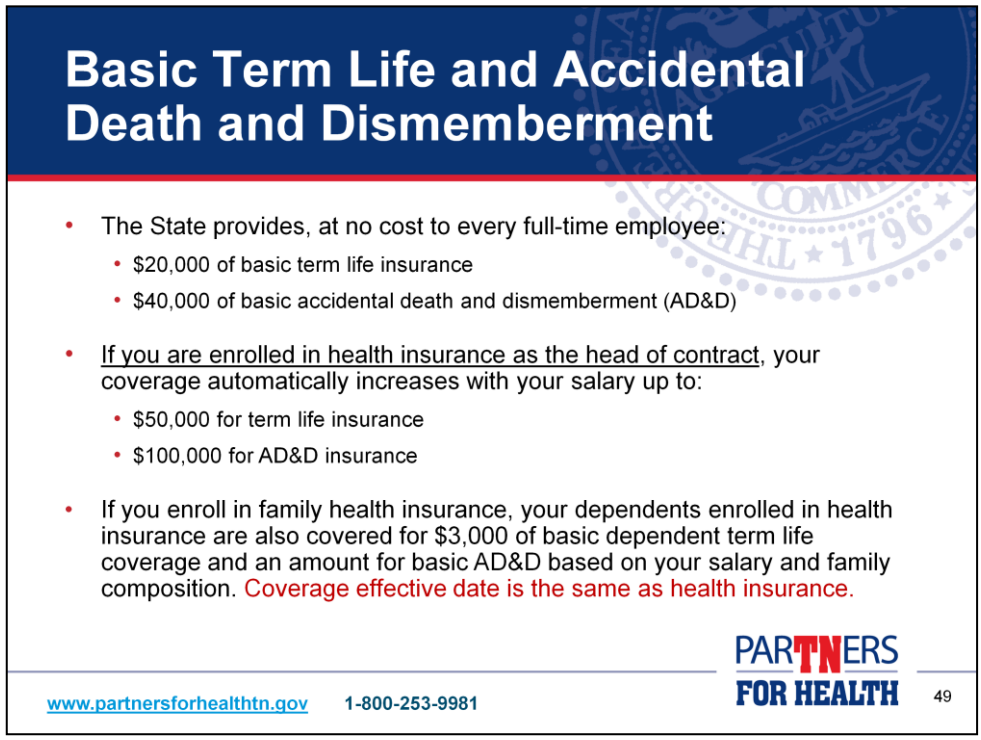
Wellness Resources:

- **Health coaching** offers professional support to create and meet goals to improve your health. Call Healthways at 888.741.3390 to talk to a health coach.
- **Well-Being Assessment** (WBA) is an online questionnaire that is available to help you learn more about your health and identify any potential risks. Login to your Well-Being Account and complete the Well-Being Assessment (WBA) at any time to learn more about your health. New Partnership PPO members must complete the WBA within 120 days.
- **Nurse Advice Line** gives you medical information and support 24/7 at no cost to you. Call 888.741.3390 to speak to a nurse.
- **Quarterly Wellness Challenges** offer a fun way to help you develop a healthier lifestyle while providing group support. Login to your Well-Being Account to join a challenge.

- **Weight Watchers at Work discounts** and **Fitness Center discounts** offer affordable ways for members to improve their health.
- **Additional wellness and fitness discounts** are available through the EAP program and our carriers **BCBST** and **Cigna**.
- To access any of these services offered by the wellness program, contact the ParTNers for Health Wellness Program using the links on the ParTNers for Health website or call **1-888-741-3390.**



- The *Working for a Healthier Tennessee* initiative was implemented under the leadership of Governor Bill Haslam and is supported by the ParTNers for Health Wellness Program and the ParTNers Employee Assistance Program.
- The *Working for a Healthier Tennessee* program builds on the foundation of the existing Wellness Program by expanding certain wellness resources to employees regardless of whether or not they are enrolled in health coverage.
- The goal of *Working for a Healthier Tennessee* is to encourage and enable employees to lead healthier lives. Some Higher Education institutions have a Site Champion who provides ideas and activities to help employees improve in three key areas: physical activity, healthy eating and tobacco cessation.
- We encourage you to become involved in activities and events designed by your Site Champion, if your institution has one.

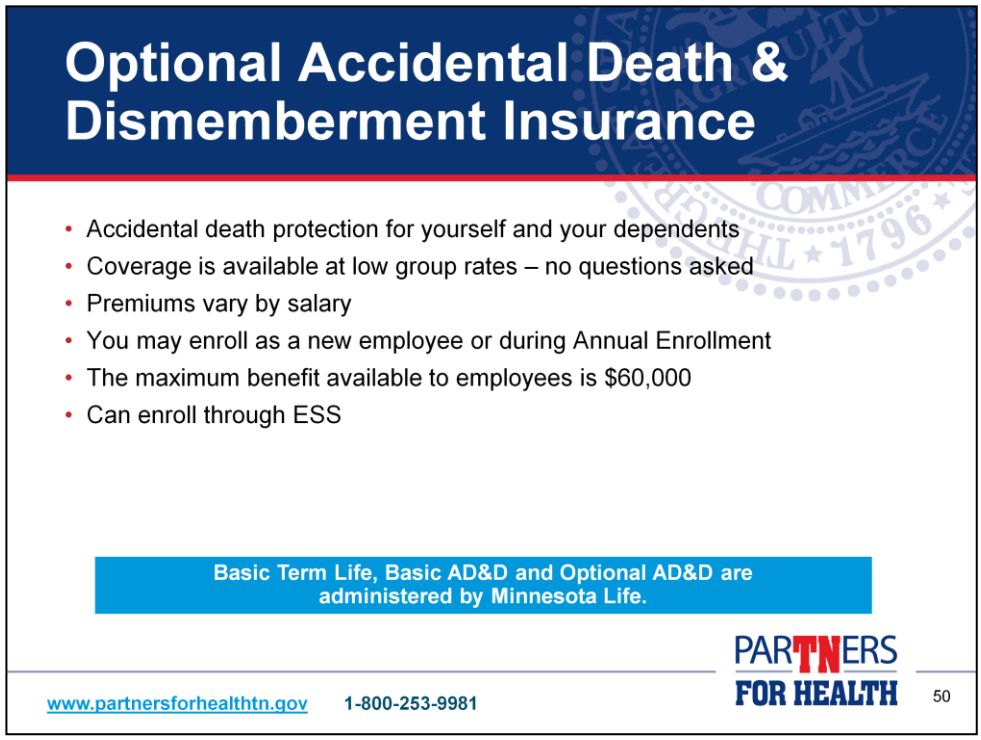


- The State provides, at no cost to you, $20,000 of basic term life insurance and $40,000 of basic accidental death and dismemberment insurance coverage. You are automatically enrolled for this coverage when you are hired.
  - **The amount of basic term and basic accidental death and dismemberment begins to decrease when the employee reaches the age of 65.**
- If you enroll in health coverage, the amount of coverage automatically increases as your salary increases, with premiums for coverage above the $20,000 and $40,000 amounts automatically deducted from your paycheck. The maximum amount of coverage is $50,000 for basic term life insurance and $100,000 for accidental death and dismemberment insurance. For employees who do not enroll in health coverage, the amount of coverage does not increase regardless of salary.
- If you enroll in family health coverage, your dependents enrolled in health insurance are also covered for $3,000 of basic dependent term life coverage and an amount for basic accidental death and dismemberment based on your salary and family composition. Remember, if you do not enroll in family health coverage, your dependents are not eligible for this coverage.
- There are also new **Life Insurance Resources** for employees:
  - Travel assistance: Pre-trip resources as well as emergency assistance

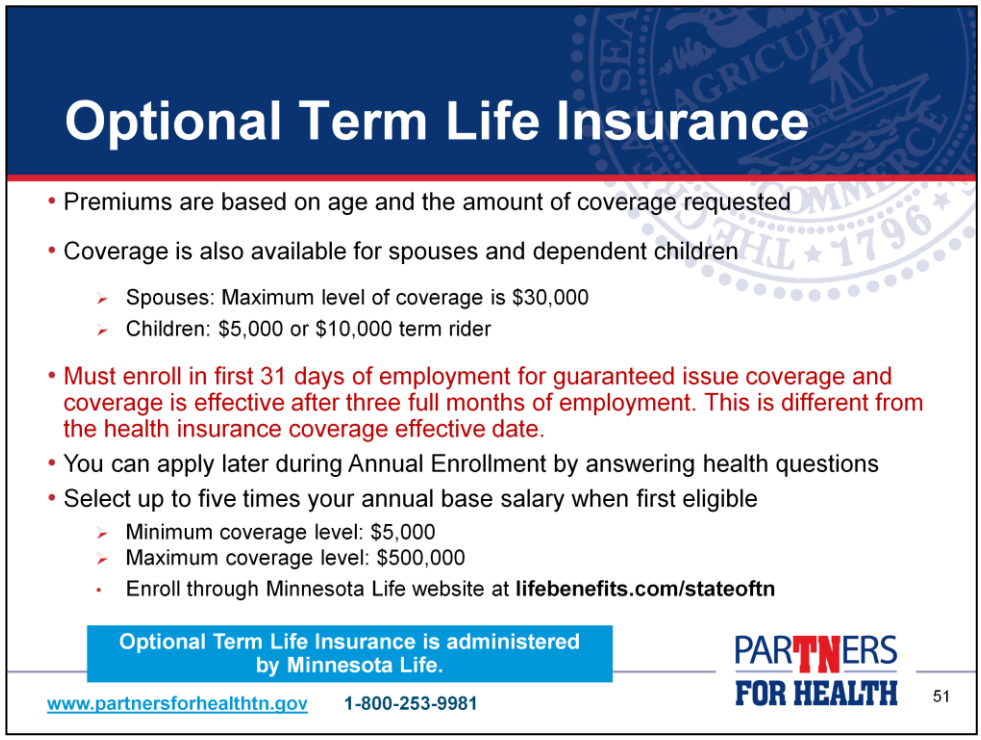
and transport services available 24/7 when 100+ miles from home.

- Beneficiary Financial Counseling: Independent financial counseling services for beneficiaries.
- Legacy Planning Resources: Assistance with resources designed to help families plan for end-of-life issues.

➢ You can go to **partnersforhealthtn.gov** for more information.



- In addition to the basic coverage, you and your dependents may also enroll in optional accidental death and dismemberment coverage. This coverage comes with an additional premium and pays an additional amount in the case of accidental death or dismemberment. New employees may enroll at the time they are hired or during Annual Enrollment each fall.
  - Coverage is available at low group rates, no questions asked.
- Premiums vary by salary.
- The maximum benefit for employees is $60,000.
- Enroll in Optional Accidental Death & Dismemberment Insurance through Edison (ESS).
- Basic Term Life, Basic Accidental Death and Dismemberment (AD&D) and Optional Accidental Death and Dismemberment (AD&D) insurance are administered by Minnesota Life. You can find contact information for Minnesota Life on the inside cover of your Eligibility and Enrollment Guide.
- For more information you can also go to **partnersforhealthtn.gov**.

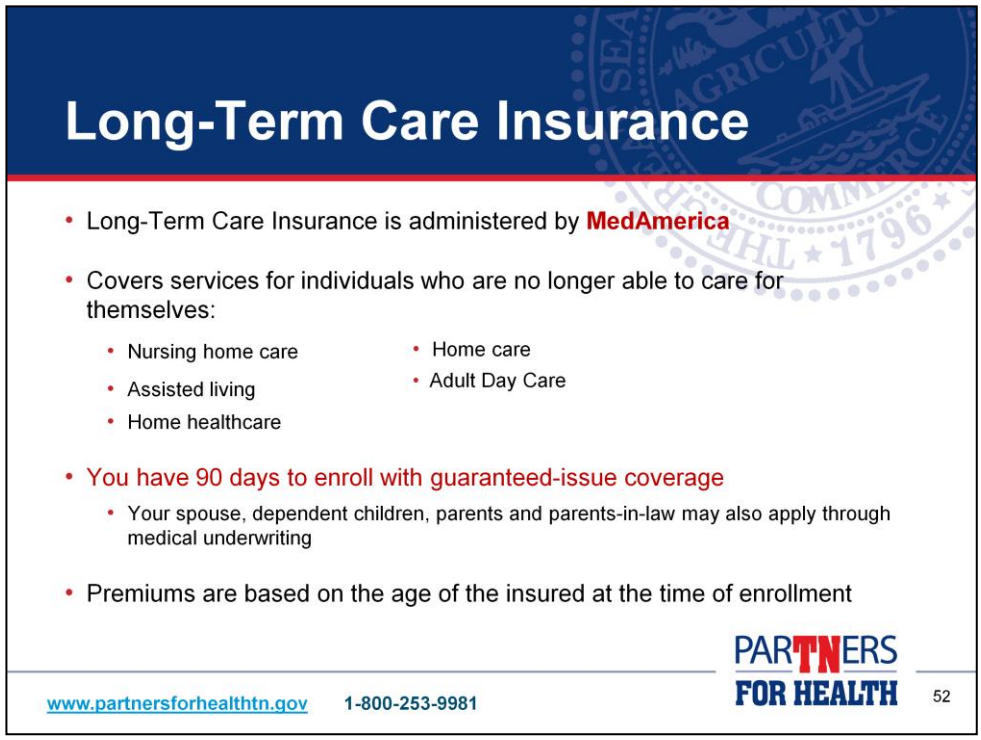


- For many people, the basic life insurance benefits provide enough coverage for final arrangements. However, the State also recognizes that the kind of insurance you need can change according to your age and stage of life. That's why the State gives you the chance to buy an additional kind of coverage: Optional term life insurance.
- Premiums for this plan are based on age and the amount of coverage requested. Optional Term Life insurance is a plan you own as an individual. That means you can keep the coverage if you leave your job or retire.
- You and your dependent spouse and children may enroll in this coverage regardless of whether you enroll in health coverage.
- For guaranteed issue coverage, you must enroll during the first 31 calendar days of employment. The effective date of coverage is the first of the month after you complete three full calendar months of employment. If you do not enroll when first eligible, you can apply for coverage during Annual Enrollment by answering health questions.
- You may select up to five times your annual base salary if you apply when first eligible. You may apply for up to seven times your annual base salary, but evidence of good health is required. The minimum coverage level is $5,000 and the maximum coverage level is $500,000.
- Your spouse may have $5,000, $10,000 or $15,000 of term life insurance at any age. Spouses below age 55 are eligible for increments of $5,000, subject to an overall maximum of $30,000. Proof of good health is required for spouse to enroll.
- Children may be covered under either a $5,000 or a $10,000 term rider. Proof of good health is not required for children.
- Enroll in Optional Term Life Insurance through Minnesota Life website at **lifebenefits.com/stateoftn**.
- Optional term life insurance product is administered by Minnesota Life.

- **Note:** You can now designate beneficiaries in Edison for Basic Term Life, Accidental

Death & Dismemberment and Optional Accidental Death & Dismemberment.

- To add beneficiaries through the main menu select ESS → Benefits → Dependents and Beneficiaries → Life Insurance Beneficiaries.



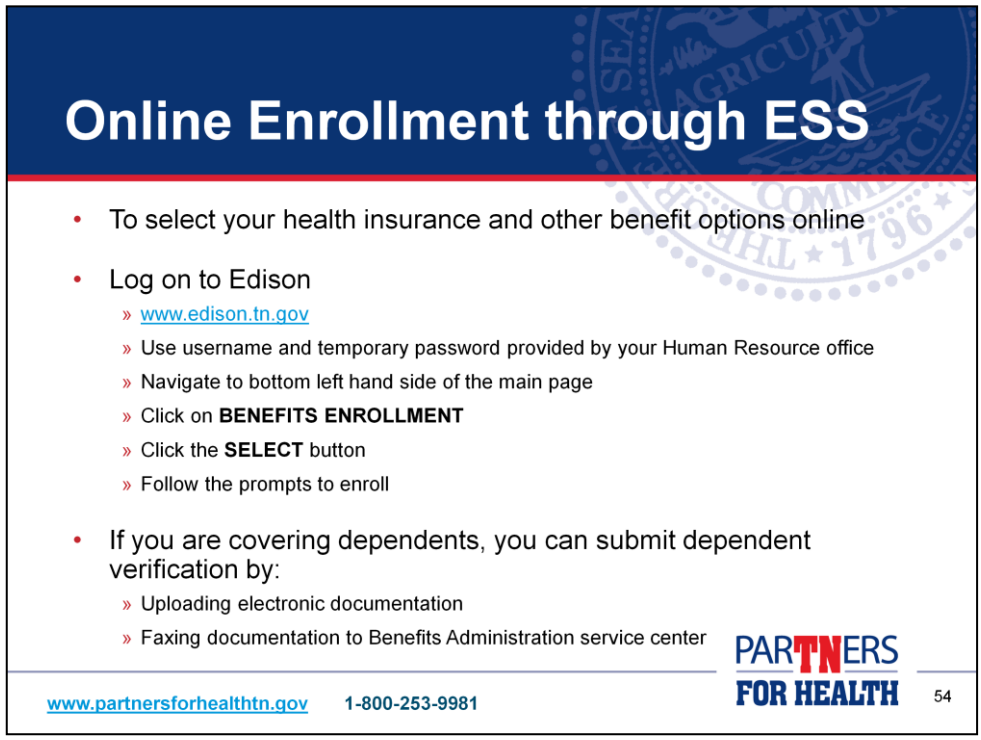
- Qualified employees, their eligible dependents (spouse and children ages 18 – 25), retirees, parents and parents-in-law are eligible to enroll in long-term care coverage through MedAmerica.
- This insurance covers certain services required by individuals who are no longer able to care for themselves without the assistance of others. Natural aging, a serious illness or an accident may bring on this need.
- Services covered include nursing home care, assisted living, home healthcare, home care and adult day care.
- As a new employee, you have 90 days to enroll and have guaranteed-issue coverage. This means you will be allowed to enroll regardless of your health, age, gender or other factors that might predict your use of health services, such as a pre-existing condition.
  - If you wait until later to enroll, you may still apply for coverage, but will be subject to medical underwriting review for approval to enroll. Your spouse, eligible dependent children (ages 18 through 26), parents and parents-in-law may also apply for coverage; however, they must answer questions about their health status and will be subject to medical underwriting review for approval to enroll. Medical underwriting is a process used by insurance companies to evaluate whether they will accept an applicant for coverage.
- The premium for this optional program is the full responsibility of the member. Premiums are based on the age of the insured at the time of enrollment. So the younger you are when you apply, the lower your monthly

premium will be. You may choose to have the monthly premium taken from your payroll check or may opt for a direct bill arrangement with the carrier for quarterly, semi-annual or annual premium payment.

- See the inside cover of the Eligibility and Enrollment Guide for MedAmerica's contact information.

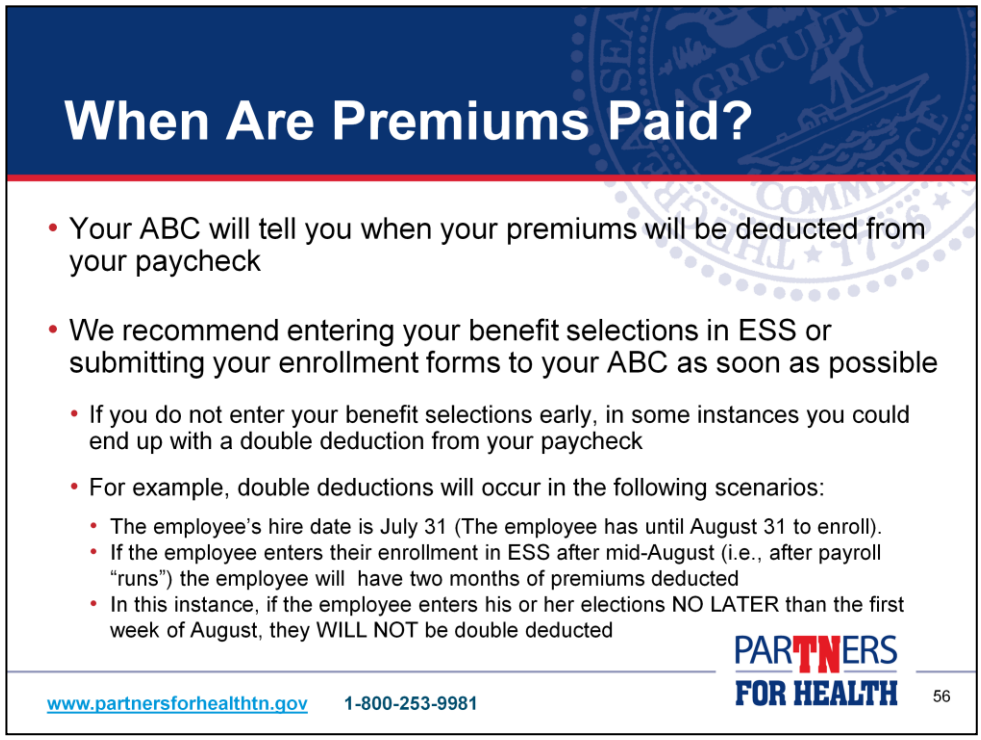
- If you choose to enroll in health, dental, vision and optional AD&D benefits, there are two ways to enroll:
  - One option is to complete a paper form called the Enrollment Change Application. If you choose to use the paper application, you will return this form to your ABC once you have made your selections. Your ABC will sign the form and submit it to Benefits Administration to process.
  - A better option is to submit your benefit selections online using Edison Employee Self-Service or ESS for short. ESS allows you to make your selections electronically, which many employees find to be faster and easier than the paper form.
- Enrollment must be completed within 31 days of your hire date. If you want to cover your spouse or children, you will also need to provide documentation during this time to verify their relationship to you. Examples of dependent verification can include a marriage license and Federal Income Tax Return for a spouse or a birth certificate for a child. A complete list of required documentation for dependent verification can be found on the BA website (**tn.gov/finance/ins**) under the **Forms** tab in the **Health and Dental** box.
- If you choose to enroll in any of the optional products we've discussed in this presentation, please consult their individual enrollment forms for submission deadlines. All enrollment forms will be provided by your ABC.
  - **Please note:** Optional Term Life enrollment is available through Minnesota Life's website or by a paper enrollment form.

- Also, Optional Long-Term Care Insurance enrollment is available through the MedAmerica website or by completing a paper enrollment form.

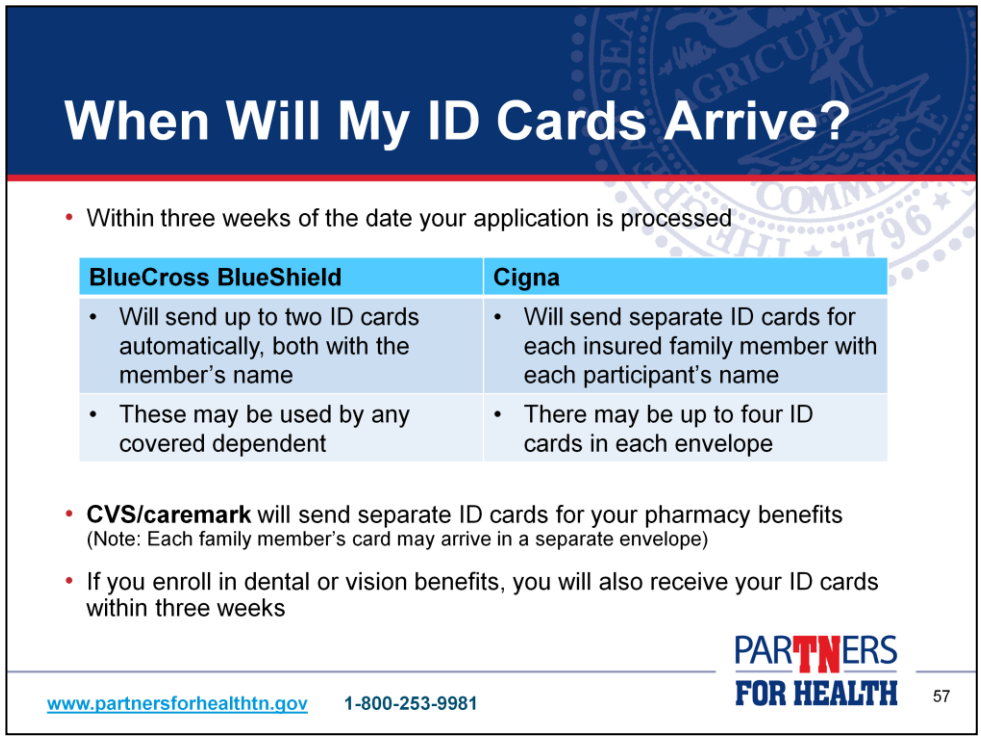


- As an alternative to submitting a paper enrollment form, your employer may allow online enrollment through Employee Self-Service. Your ABC will advise if ESS is available to you.
- Online enrollment is easy and convenient. Simply log in to Edison using the username and temporary password provided by your Human Resource office or ABC. Navigate to bottom left hand side of the main page and select "**Benefits Enrollment**". You will then click on the "**Select**" button to start enrollment. Follow the prompts to make your selections and the system will take you through the rest of the process.
- If you are covering dependents, you can submit your dependent verification by uploading copies of the appropriate documentation in Edison. Or, if you do not have electronic copies, you may also fax the required documentation to the Benefits Administration service center at 615-741-8196.

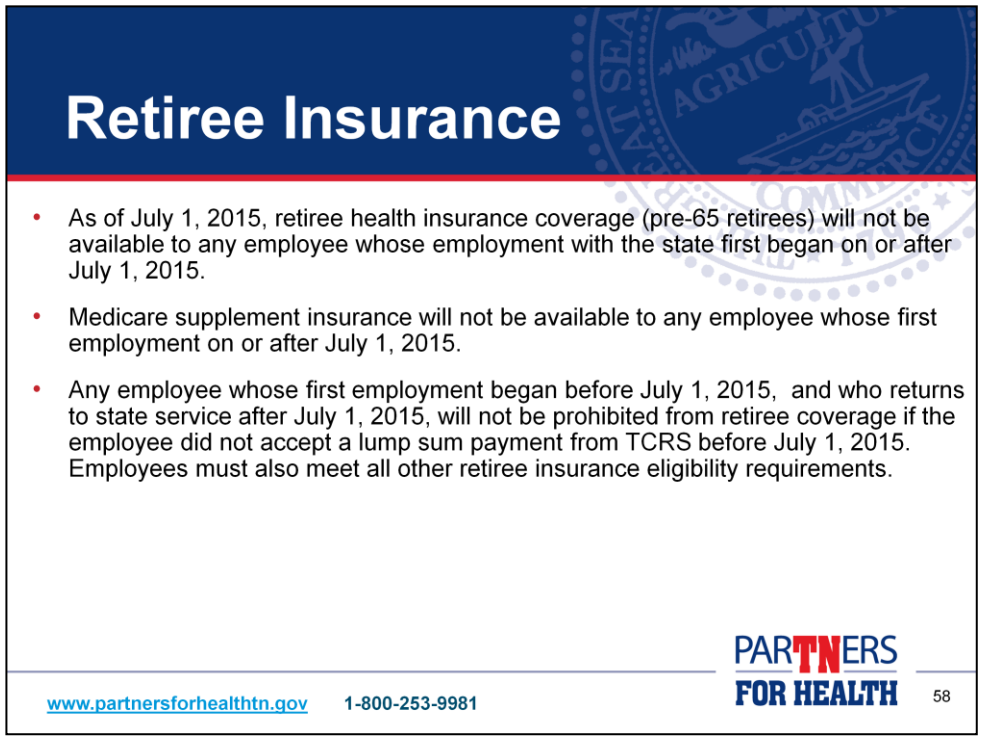
- Once you enroll, your health, vision and dental coverage will begin on the first day of the month after one full calendar month of employment from your hire date.
  - For example, if you are hired September 15th, your coverage will begin on November 1st. Your ABC can help if you have questions about when your coverage begins.



- Your ABC will tell you when your premiums will be deducted from your paycheck.
- We do recommend entering your benefit selections in ESS or submitting your enrollment forms to your ABC as soon as possible.
- If you do not enter your benefit selections early, In some instances, you could end up with a double deduction from your paycheck.
- For example, double deductions will occur in the following scenarios:
  - The employee's hire date is July 31 (The employee has until August 31 to enroll).
  - If the employee enters their enrollment in ESS after mid-August (i.e., after payroll "runs") the employee will have two months of premiums deducted.
  - In this instance, if the employee enters his or her elections NO LATER than the first week of August, they WILL NOT be double deducted.



- Once your enrollment application has been processed, you will generally receive your new health insurance ID cards within three weeks.
- If you enrolled in health coverage with BlueCross BlueShield, you will receive up to two ID cards automatically. The member's name will be printed on all cards, but these cards may be used by any covered dependent.
- If you choose health coverage with Cigna, you will receive separate ID cards for each insured family member with the participant's name printed on each. Cigna will send up to four ID cards in each envelope and additional ID cards in a separate envelope.
- After you receive your initial cards, if you need additional ID cards, you can request them by contacting the carriers directly.
- In addition to your health insurance ID cards, you will also automatically receive separate pharmacy ID cards. If you are enrolled in family coverage, your ID cards may be sent in separate envelopes.
- If you enroll in dental or vision coverage, you will typically receive your ID cards within three weeks.



- A new law regarding retiree insurance was approved by the legislature in April of 2015.
- As of July 1, 2015, retiree health insurance coverage for pre-65 retirees will not be available to any employee whose first employment with the state began on or after July 1, 2015. Employees hired before July 1, 2015, will be grandfathered in.
- Medicare supplement medical insurance will not be available to any employees whose first employment with the state began on or after July 1, 2015. Employees hired before July 1, 2015 will be grandfathered in.
  - But any employee whose first state employment began before July 1, 2015, and who returns to state service after July 1, 2015, may participate in retiree coverage if the employee did not accept a lump sum payment from TCRS before July 1, 2015, and if the employee meets eligibility requirements for retiree insurance.
- If you have questions about the above or your insurance options, we encourage you to talk to your Agency Benefits Coordinator (ABC).

- Your privacy is important to us, and all of our members' personal health information is strictly confidential. Your health privacy rights are protected through a federal law called HIPAA. Simply stated, this law requires your personal health information not be shared without your consent. For that reason, Benefits Administration can only discuss benefit information with the employee who is enrolling in coverage, also known as the head of contract or HOC.
- If you would like to grant Benefits Administration permission to speak to someone other than you about your benefits, please complete and submit an Authorization for Release of Protected Health Information form to Benefits Administration. This will allow your spouse or another individual of your choosing to receive your health information on your behalf. This form is available in the forms section of our website or from your ABC.
- Please note that your personal health information may be used or disclosed by and within each plan as well as the State Group Insurance Program third-party "business associates" or contractors as needed for your treatment, payment of benefits or other health care plan operations.

- BlueCross BlueShield, Cigna and CVS/caremark each offer member websites that allow you to view detailed information about your claims, print temporary ID cards and access other helpful member services. These member websites offer a convenient way to keep track of your health insurance benefit information. All you have to do is create an online account to get started.
- For more information, use the links listed at the bottom of this screen.

- We have covered a lot of new information in this presentation, so it's important to know who to ask if you have questions or need more information at a later time. Your ABC will be your primary point of contact, and he or she will be able to answer many of your benefits-related questions or help point you in the right direction.
- If you have questions about a provider or insurance claim, contact your insurance carrier directly. You can find your carrier's number listed on the inside cover of the Eligibility and Enrollment Guide or by visiting their member website. Once you receive your ID card, you can also find the carrier's phone number listed on the back of your card.
- If you have specific questions regarding eligibility or enrollment in benefits, you may call the Benefits Administration service center at 1-800-253-9981.
- At the bottom of this slide you will find the web addresses for the ParTNers for Health and Benefits Administration websites. These websites are great resources that contain additional information about the subjects discussed in this presentation, as well as direct links to all of our benefit partner websites.

- This concludes the new employee benefits orientation. To watch this presentation again, or to access the forms and other resources discussed during this presentation, visit the Benefits Administration New Employee Page. Go to www.TN.gov/finance/ins and click on the New Employee tab on the left side of your screen.
- Thank you for your attention during this presentation. If you have questions, please ask your Agency Benefits Coordinator at this time.